enhanced SEA

NHS Education for Scotland

SUBMISSION REPORT FORM

TITLE OF REPORT:	Misplaced IUS
NAME:	Dr Smith
CORRESPONDING ADDRESS:	Smith Medical Centre, 101 Smith Street, Smithstoun, SS99 9SS
TEL:	0000 000 0000
EMAIL:	dr.smith@smith.nhs.ukk
DATE OF SUBMISSION:	July 2015

The peer feedback that you receive on your SEA report can also include judgement on whether it is 'satisfactory' or 'unsatisfactory'. Please indicate by if you wish to know this judgement.

Yes ☐

No ☐

Tick here if this is your first ever significant event analysis ☐

The information provided may be used for training purposes. Should you not wish the information to be used, please tick this box ☐

- Evidence suggests that the application of 'Human Factors' knowledge enhances performance in the workplace and improves understanding of the **complex human-system interactions** which contribute to significant events.
- A simple way to view the discipline of 'Human Factors' is to think about the interactions between three work-related factors: **People, Activity** and the **Environment** – and how they can combine to impact on people's health, safety-related behaviour and patient care.
- This report can be completed after analysing the significant event on your own, or it can reflect the comprehensive analysis carried out by your wider care team.
- The key to a more **in-depth analysis** is identifying the human-system interactions that **contributed** to a significant event.
- A deeper understanding of why the event happened will prompt a more focused, meaningful and detailed **Action Plan** for improvement.

1.About the Significant Event

Please describe what happened

(e.g. outline in sufficient chronological detail including how it happened, who it happened to and the location of the event).

A letter from a patient sent to Smith Hospital was forwarded to the practice. She complained that I had inserted a mirena coil which subsequently was found to be extra-uterine and that she would have to undergo surgery for removal. She also mentioned that there had been a delay in requesting and U/S scan to identify where the IUS was. The chronology and details are included in the letter sent to the patient, as they are quite detailed, but in summary she attended for a counselling appointment with me, then a review appointment for IUS insertion which was straightforward. A six week post-natal appointment was kept and at that time threads were documented as being visualised. She attended for a smear appointment several weeks later at which time the practice nurse noted that no threads were visualised and a note was sent to me to refer for an U/S scan. It was during summer holidays and there was a delay in doing the referral, but she attended for a scan which commented no IUS visualised, but co-incidentally an ovarian cyst was noted and that this should be followed up 6/52 later.

This was arranged and as it was still present a routine gynaecology appointment was arranged. When she was seen several months later by gynaecologist, the ovarian cyst had resolved but the gynaecologist requested a pelvic x-ray to check the IUS was not extra-utero. This showed the IUS lying in the pelvic area extra-utero.

Throughout, when the threads were not visualised, she had been counselled regarding potential pregnancy and has opted to start the COC.

What was the impact or potential impact of the event?

(e.g. on the patient/relatives, yourself, colleagues/staff – think in terms clinical, professional and organisational risks and implications).

This lady could have, but fortunately didn't, become pregnant. Also she could have experienced symptoms of pain and less likely bowel perforation. Fortunately, throughout she has had no symptoms and it was discovered almost co-incidentally.

She now faces surgery, which due to previous pelvic surgery will be more major, rather than a laparoscopic approach.

2.Contributory Human & System Factors

Please outline the different factors that contributed to WHY the event happened.

People Factors *(e.g. consider the people (ill patients/clients, staff interactions) who were directly and indirectly involved in the event and the communications between them and other factors).*
Activity Factors *(e.g. complexity of the work task, lack of recognised care guidance or design of system or process).*
Environment Factors *(e.g. consider practice culture, time and workload pressures, adequacy of equipment, available lighting, noise levels, distractions and interruptions.*

Perforation or loss of IUS (falling out) are well recognised complications of IUD/S procedures. The Patient Information Leaflet (PIL) which is given out contains this information and it is my normal routine to discuss this at the counselling appointment.

The IUS insertion was easy - I do remember it and she tolerated it very well with no discomfort or difficulty. It is interesting that threads were visualised at the 6-week check but several weeks later were not. I can only surmise that the IUS was extruding through the uterine wall slowly.

When the radiology report documented no IUS visualised I assumed it had fallen out, as I would have expected it to have shown up on the u/s, albeit extra-uterine. It was only detected after the gynaecologist requested a pelvic x-ray. Throughout she had no complaints of abdominal pain or symptomatology.

The delay in requesting the u/s likely occurred as it was over summer holiday time and was therefore overlooked.

Please describe how these factors combined to make the event happen.

(Think in-depth about the interactions between people, the activity you were undertaking, the practice and wider healthcare systems and environment that you work in).

There was a delay in requesting the ultrasound initially, then a further delay waiting for a repeat scan, delays in being seen by gynaecology and delays in gynaecology follow-up after the pelvic x-ray (4 months), so that form attending with the non visualised threads to being advised by gynaecology that her IUS was extra-utero took nine months.

Did you identify these factors on your own or with input from other colleagues?

I reviewed her case notes carefully after receiving the complaint, constructed a reply with the practice manager and took advice from the MDDUS.

3.Lessons Learned

What lessons have been learned from the analysis of this event?
(Think again about the complex interactions between People, Activity and Environment).

Even with expertise and experience, complications happen. Thus us a recognised complication and appropriate counselling had been given.

The delay in requesting the initial u/s shouldn't have happened-human error; and it was only when she mentioned to the health care assistant that she hadn't had her scan that it was further actioned. A messaging system electronically would be better than a slip of paper which can be overlooked. Email messaging is now used for similar requests, which have an audit trail.

I will be much more vigilant in future when undertaking u/s requests and consider mis-placed IUD/Ss if absent.

What learning needs have been identified (at the individual, care team, and organisational levels, where appropriate)?

I have undertaken a review of my IUD/S insertions over the preceding year.

4.Action Plan for Improvement

How have you minimised the chances of this event happening again?
(Outline your Action Plan for Improvement and how you have implemented it together with the role and contribution of the wider care team, where appropriate. If you have yet to take action or judge that no action is necessary, please justify why this is the case).

Who is responsible for ensuring that these actions are implemented and how will these be monitored and sustained in practice?
(Outline your role and contributions and those of the wider care team, where appropriate).