South Tees Hospitals NHS
NHS Foundation Trust

Learning the lessons Cardiothoracic HDU

…improving patient care and clinical governance by sharing the lessons learned …

2 incidents October 2016 & August 2017 - arterial line accidently cut resulting in surgical removal of retained tip

Situation and Context	Intention to remove arterial line as no longer clinically indicated. Arterial line and peripheral cannula in close proximity in forearm and nurse was attempting to retain the one working cannula and associated dressing
Issue	Arterial line to radial artery at wrist accidently cut during attempt to separate overlapping dressings resulting in the line being retained in the artery. Observation of arterial line obscured due to multiple dressings Lines inserted in close proximity for the following reasons • 1 patient had thoracic surgery and due to lateral position on operating table the upper arm was most accessible . Arterial line required as patient COPD requiring arterial gas monitoring . 1 peripheral cannula for propofol infusion, 1 for infusion of fluids • 1 patient had cardiac surgery .Non dominant arm used for arterial line and large peripheral vein cannulation for anaesthetic induction/ rapid fluid infusion
Consequence	• 2 patients required surgical removal of retained arterial line caused by accidental severing using scissors • 1 formal complaint made by affected patient
Lessons	• **NEVER** use scissors near any invasive lines including arterial lines, central lines and pacing wires • **ALWAYS** get help from another member of staff to ensure invasive line is held firm while dressings removed • Nurses staff to ensure that arterial lines are visible by using transparent dressings s per Trust arterial line pathway.. Avoid placing additional tape/ dressings that may obscure view. • Practice of siting lines in close proximity explored with Clinical director for Cardiothoracic Anaesthetists but deemed clinically necessary in some instances • CHDU Staff to sign signatory list as assurance that bulletin read and understood
Further actions	• serious learning event investigation report completed • report shared at Trust Patient safety panel • local arterial line competency to be developed and completed by CICU/CHDU staff as additional assurance of safe practice • to share wider within Trust • explore if similar instances have occurred

Claire Holmes Deputy Manager CHDU

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Electronic copies of lessons learnt available on G drive- cardio HDU