

## **Response to Regulation 28: Report to Prevent Future Deaths**

Issued following the inquest into the death of Lydia Corah held on 11<sup>th</sup> May 2015.

### **Matters of Concern:**

1. That there was an error, or series of errors, which led to Lydia Corah undergoing an xray which had been indicated for a different patient, so causing her to experience delay in assessment and treatment and to receive an unnecessary dose of radiation.
2. That the same error, or series of errors, would have adversely affected the patient for whom the xray request had been properly intended.

### **Response**

1.
  - a. Incorrect patient identification leading to inadvertent and unnecessary exposure to radiation is a recognised concern within the health service and is monitored by the Care Quality Commission (CQC) under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
  - b. CQC data for 2013 (latest available) records 968 events reported in England. The report states; *Of these 968 notifications, 781 (81% of the total) were from diagnostic radiology departments. Well over a third of these errors resulted in the 'wrong patient' undergoing a diagnostic imaging examination. However, using established radiation risk factors and excluding any social or psychological detriment, the impact on the patients involved in the majority of cases is judged to be relatively small.* The 2013 report can be found at:  
[http://www.cqc.org.uk/sites/default/files/20140721\\_irmer\\_annual\\_report\\_final.PDF](http://www.cqc.org.uk/sites/default/files/20140721_irmer_annual_report_final.PDF)
  - c. It is recognised that these events are under reported and the actual number of incidents will be higher than identified in the report.
  - d. NUH data records 4 incidents of incorrect patient radiation in 2014.
  - e. A Root Cause Analysis is routinely employed in all cases of incorrect referrals for medical imaging. The RCA will generate an action plan which is managed by the responsible Directorate. The RCA for this patient is attached (appendix 1). It is difficult to be certain of the cause of the patient identification error. The experienced (Consultant) investigator concludes that the most likely cause to be a mistake whilst using the electronic requesting system (Notis). It is possible to open multiple pages whilst using this system and this has been highlighted as a potential cause for ordering an investigation on the incorrect patient as each open page will belong to a different patient. This type of error is often associated with trainee doctors engaged with caring for more than one patient at busy times.

- f. The NUH Information Technology department has previously highlighted the issue of multiple pages on Notis, and have strengthened the induction training of new doctors in this regard. An assessment of this issue has not provided a technological safeguard as potential barriers to this error were thought to create their own patient safety concerns.
- g. The only additional safeguard which has been proposed is the inclusion of a patient photo to the Notis page. This has not been progressed but will be considered in the near future by the NUH Clinical Risk Committee.
- h. A failure in this case also occurred within xray as the clinical details provided indicated that the patient was 26 years old. This was not considered by the radiographer.
- i. An incident report from Radiography is attached (appendix 2).
- j. This report highlights the way clinical details are provided to the radiographer from the Computerised Radiology Information System (CRIS). Two areas for examination were requested and this required two separate entries for clinical detail. The thoracic spine detail did not include the age of the patient and it is concluded that the radiographer would have read this information and did not read the additional details for the lumbar spine (which did include the age of the patient).
- k. The radiography report arrives at recommendations which has generated an Action Plan (appendix 3) managed by the Directorate. These actions are complete and include reflection by the member of staff involved and updating of checking procedures including assessment of the clinical details and how to manage discrepancies.

2.

- a. The second area of concern within the PFD notice is the potential delay to diagnosis for the patient for whom the xray had been properly intended.
- b. The correct patient has been identified and the correct investigation was performed prior to the xray attendance of Lydia Corah. We therefore conclude that the error identified did not delay the correct investigation of the correct patient.
- c. The radiographer involved in this investigation was different from the one involved with Lydia Corah and therefore there was no opportunity to be alerted to the dual request.

## **Summary**

Incorrect patient radiation is a recognised concern within the NHS directly reportable to the CQC. Nottingham University Hospital has been active in analysing the factors associated these patient identification errors. Incorrect patient selection using the hospital Notis system has been highlighted as a patient safety issue and enhanced induction training has been implemented to reduce these errors. Other technological solutions have been considered but not implemented due to other patient safety concerns.

NUH has an established system to report and investigate incidents involving Ionising Radiation when they are recognised.

NUH recognise the seriousness of this avoidable delay to urgent treatment caused by this error in patient identification. The Trust Clinical Risk Committee will consider further the possibility of providing more robust technological barriers to incorrect patient selection within the Notis system.