Guidewire left in Situ (Never event) - June 2022

Learning Summary from Incident Reviews and Investigations

Category:	Treatment / procedure inappropriate / wrong
Speciality:	Critical (Intensive) Care (ITU)
When	June 2022
Reference	195517
Keywords	Guidewire (Never event)

Incident Summary

The multi-disciplinary team took swift action to prepare a deteriorating patient for theatre

There were many factors identified, the team worked to stabilise the patient who had a good outcome

Our investigation found learning points for sharing across clinical teams.

Summary of findings

Communication:

- The safety checklist including verbal confirmation of guidewire removal must be completed by the team placing medical devices at the time of procedure.
- before handover, there should be a pause between clinical procedures to provide an accurate situational report and a structured handover of care to ensure full information is given

Imaging:

- Referrals to radiology to check placement of devices must include sufficient information regarding the number of devices in situ
- Additional equipment, such as monitoring wires, should be moved outside of the field of view on the chest x-rays to increase visibility of medical devices which require placement check.