NHS
Hampshire and Isle of Wight

Primary Care Shared Connection

April 2024

Incidents Involving Medical Fridges – updated

The ICB supports practices by analysing themes from Significant Events. On some occasions, themes or single events are identified that require prompt sharing to all Primary Care practices to enable learning.

Particular Interest	☐All Staff ☒Practice Managers ☒GP's ☒Nursing ☐AHP ☐Clerical ☐Other
Summary	Following the installation of a new fridge in a Primary Care setting, the appliance was accidentally switched off overnight instead of being reset as intended.
Impact	Clinical and operational impacts: • A variety of medications and vaccines in the fridge were affected by the cold chain disruption, leading to a number of them being quarantined and unavailable whilst guidance from vaccine manufacturers was sought. • Clinical time used seeking clarity on vaccine usage and resolving the problem • Although there was no medication lost, there is an associated financial risk with potential loss of vaccines

Identified learning	A systems analysis approach identified several learning points, however key conclusions were as follows:
	• Fridge design varied considerably (both between manufacturers and even across their respective product ranges).
	• The new fridge introduced potential, unforeseen complexities:
	  ○ 'person factors' e.g. training challenges re. operating instructions
	  ○ 'technological factors' e.g. design interaction made it easy to hit the wrong button
	  ○ 'task related factors' e.g. the new fridge changed the sequencing of an otherwise familiar task

Suggested actions	• Providers should consider the way existing equipment is designed & used when replacing or ordering new/additional equipment. • Primary Care settings should ensure that relevant clinical staff are fully aware of/familiar with new equipment (to avoid presumption that replaced equipment is 'like-for-like'). • Consider affixing appropriate warnings/labels to equipment where there is a known risk of it being switched off accidentally. • Consider affixing 'quick reference' operating instructions to equipment, • Always ensure that a hard-copy instruction/operating manual is available – Do NOT rely solely on QR codes or other mean that direct users to online resources. • Consider introducing 'double-check' processes where possible – e.g., two-person verification of a task. *NB. These suggested actions are not exclusive to fridge issues and may be applicable to a variety of clinical equipment-related scenarios.*
For further information and support contact:	• Please refer to your regional/local ICB Quality Team • UKHSA (2022) Vaccine incident guidance Responding to errors in vaccine storage, handling and administration