

Risk Assessment Form HS 9 (2)

Location/Activity: Generic Risk Assessment for McKinley Syringe Drivers **Date:** _____ **Review date** _____

Patient's Full Name:	Date of Birth:	NHS Number:
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Assessor Name: _____ Signature: _____ Designation _____

Ref	Hazards	Risks	People at risk	Current Control Measures	L x C = R			Is further action required (Y/N)
					L	C	R	
1	McKinley pump will not accept syringe	Wrong syringe or size of syringe is used to set up syringe driver	Patient Potential for patient to be under dosed or over dosed	1. McKinley pump has been calibrated to only accept 30ml BD Plastipak Luer Lock Syringe	1	4	4	
2.	Potential risk of battery level falling below 40% during the 24 hour period	Patients may receive insufficient medication Symptoms may not be relieved. Potential Medication error	Patient	1. All staff to check battery level prior to setting up syringe driver, this can be achieved by pressing the 'Info' key 2. Battery level must be a minimum of 40% to ensure the battery will last for 24 hour period 3. Always check battery level at each visit and record on syringe driver checklist 4. The pump will alarm if battery depleted 5. If battery requires changing mid infusion, stop pump and power off. Change battery and start up pump and press 'Yes' to resume the infusion	2	2	4	

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3	Extension set at risk of entrapment	Extension set may become occluded Patients may receive insufficient medication Symptoms may not be relieved. Potential Medication error	Patient	<ol style="list-style-type: none"> 1. Always check that the extension line is not trapped in the locked box 2. Check extension line each visit and record on syringe driver checklist 3. Explain to the patient/relatives the risks of tampering with syringe driver 4. Provide patient with information leaflet 	3	2	6	
4.	Start-up sequence not followed correctly	Medication error Patient does not receive analgesia	Patient	<ol style="list-style-type: none"> 1. When starting the infusion always ensure the barrel clamp arm is down and no syringe in place 2. Press 'On/Off' key to power up 3. The actuator moves (pre loading) to the position of the last syringe that was in place at the start of the previous infusion 4. Press 'Info' key to check battery level 5. If required use FF/ Back keys to move the actuator for syringe placement 6. Load the syringe 7. The screen should display the syringe size and brand in use, if correct press 'Yes' to confirm 8. Infusion summary displays, check the programme displayed matches the patient prescription 9. Press 'Yes' to start infusion 	2	2	4	

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5.	Battery not being inserted correctly	Patient not receiving their medication	Patient	1. Check the rubber bungs have been removed prior to inserting into the syringe driver 2. Ensure that the battery terminals are inserted the correct way round – refer to the +ve and –ve symbols on the battery section in the syringe driver	3	2	6	
6.	Syringe not being properly fitted, therefore can become dislodged	Pain and distress due to under infusion of medication	Patient	1. Always use a luer lock (BD Plastipak) 30ml syringe 2. Ensure that the syringe is securely connected to the extension line. 3. Ensure that the syringe is correctly and securely fitted to the syringe driver (refer to manufacturer's instructions). Any reported faults with syringe driver or adverse events the syringe driver must be returned to EBME for checking and complete medical device inspection, servicing and repair form certificate of decontamination form stating the reported fault and request for inspection form indicating the syringe driver was faulty. Bag and Tag 4. Always secure McKinley syringe driver in locked box and store key in Envopak 5. Complete an incident form	2	2	4	

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7.	Using Syringe Drivers purchased by, relatives, charities, General Practitioners and any external agencies	Syringe driver may not have been checked by the EBME department. Cannot ensure that the driver is safe for use.	Patient	1. Only use syringe drivers that have been purchased by Wirral Community NHS Trust and ensure it is within service date (If using syringe driver from secondary care please change over to the Trust's syringe driver within 24hours)	1	2	2	

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8.	Volume to be infused/ volume remaining recorded on the pump does not match amount remaining in the syringe	Patient receiving their medication at the incorrect rate (overdose/ under dose)	Patient	1. Each visit always check the volume to be infused and volume remaining and record on syringe driver checklist. 2. If major over-infusion, stop infusion, check condition of patient and seek medical advice. 3. Check for disconnection of line or cannula 4. Check rate setting is correct 5. Check pump has not been placed above the height of the patient (Siphonage could have occurred) 6. If pump either running too fast or too slow, change the entire pump for a new one, complete medical device inspection, servicing and repair form and send the original pump back to EBME for servicing or repair. 7. If under infusion check rate setting 8. Check the infusion light status indicator is green and flashing 9. Check battery level 10. Check the contents of the syringe, extension line, evidence of crystallisation or kinking. 11 Check cannula site for any redness, hard, lumpy or sore 12. Report the incident using Trust Incident reporting system.	2	3	6	

To ensure control measures are in place to maintain patient safety all nurses must follow Wirral Community NHS Trust policies, procedures and standard operating procedures relating to the care of patients with syringe drivers.

TL = Team leader CM = Community Matron SNP = Senior Nurse Practitioner SN = Staff Nurse L= Likelihood of Re-occurrence R= Results

C= Consequence and Weighting EBME= Electronic Bio Medical Equipment.

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- Green, low risk, managed by service area Amber, high risk, managed by senior managers Red, extreme high risk, managed at director level