suboptimal in some hospitals under the EWTD.

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doi: 10.1136/qshc.2006.019489

Accepted for publication 16 June 2006

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Bedside tipples

Alcohol hand-gel is now provided at all patient–staff contact points throughout the National Health Service as part of the Department of Health's "clean your hands" campaign. This potentially could adversely influence patient care as we found out in our hospital. A 53-year-old patient admitted with alcoholic liver disease and acute renal failure consumed about 350 ml of spirigel from the container at his bedside. Gastric lavage was not considered safe and he was monitored closely over the next two days. He did not manifest any signs of ethanol intoxication and was discharged in due course. Spirigel contains 70% ethanol and small quantities of glycerol, bitrex and triethanolamine. The features of toxicity are entirely due to the ethanol. The estimated fatal dose for this gentleman was about 600 ml. The presence of bitrex and the consistency of this product discourage ingestion. However, the easy availability of this rather rich source of

alcohol could prove tempting to patients known to misuse alcohol. It is perhaps prudent to put in place measures to limit access to alcohol-containing products for this type of patients.

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doi: 10.1136/qshc.2006.019679

Accepted 30 June 2006

Competing interests: None declared.

Using a sentinel adverse incident audit on a Medicine for the Elderly ward

Adverse events in healthcare occur more often in older people,^{1,2} and older people are more vulnerable to the effects of adverse events. Despite this, there are few studies that focus specifically on reducing adverse events in older people.³ Several problems have been noted with systems such as the incident reporting (IR1) system used in the National Health Service—lack of anonymity,⁴ failure of medical staff to fill in reports,⁵ bias towards certain types of events (eg, falls) and lack of feedback to ward staff. We therefore introduced an anonymous adverse incident reporting system on our Medicine for the Elderly ward in Ninewells Hospital, Tayside, Scotland to ascertain (a) whether additional events would be detected by this system and (b) to provide a driver for ward-based quality improvement activities.

The audit ran between November 2004 and October 2005. The tool was based on a tool previously developed by one of the authors, the trial for which was conducted in general medical wards in an Australian hospital.⁶ Before its introduction, an orientation session took place at the weekly ward multidisciplinary meeting. Reports were collated at three-monthly intervals by the middle grade doctor on the ward (MDW) and presented to the

multidisciplinary team in aggregate form. These aggregate reports were then used to select a small number of areas on which to focus ward-level quality improvement activities.

In all, 268 patients, all female, mean age 85.2 years, were admitted to the ward during the study period. Table 1 compares the audit results with IR1 reports from the same timeframe and from the preceding year. A total of 32 of 72 (44%) of sentinel audit incidents were reported by nursing staff and 37 of 72 (51%) by medical staff, with three reports not attributable. No incidents were reported by allied health professionals. There was no overlap in reports between the sentinel audit and the IR1 system.

The adverse incident audit was acceptable to staff, quick to use and generated additional adverse event reports to the IR1. Event categories for both the audit and IR1 were similar to those previously reported.^{7,8} The frequency and type of events reported using the IR1 system did not change when the sentinel audit was introduced, confirming that the audit collected new information. The results were easily fed back to the ward team, who initiated new ward-level quality improvement activities as a result. A simple, anonymous adverse incident audit can therefore provide useful additional information to drive quality improvement activities in a Medicine for the Elderly hospital service.

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doi: 10.1136/qshc.2006.020180

Accepted 3 August 2006

Competing interests: None declared.

Table 1 Adverse incidents captured by sentinel audit and IR1 reports

Category	Sentinel audit 2004–5	IR1 2004–5	IR1 2003–4
Delay in investigation or diagnosis or treatment	24	0	0
Prescribing error	14	0	0
No discharge summary or notes entry	5	0	0
Inappropriate treatment	4	0	0
Unplanned readmission	4	0	0
Cancelled or inadequate discharge	4	0	0
Adverse drug reaction	4	0	0
Unprescribed fluids or warfarin	3	0	0
Over-anticoagulation	2	0	0
Observations not recorded	2	0	0
Patients with slip, trips and falls	0	110	112
Drug administration error	0	5	3
Hospital-acquired infection	0	2	0
Patient missing	0	4	1
Theft or intruder	0	3	2
Violence and aggression	0	11	11
Other injury (staff or patient)	0	8	12
Unsafe staffing levels	0	0	3
Other	6	4	4
Total	72	147	148