

Risk Watch

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Lessons from the sentinel event casebook

Potential for Error – communication issues – clinical handover

A patient was transferred to a health service for specialised investigations and treatment within the radiology unit. The treatment was successful and the patient was due to be transferred to an acute ward.

Due to pressure on beds the transfer to the acute ward was delayed, and the patient remained in the radiology unit.

This unit is staffed for short-term general recovery and observation post minor procedures. It was not equipped for very ill patients who may require more frequent observation, and long stay patients.

The patient was reviewed by several medical staff whilst within the unit, though there was no clear documented plan.

Immediately after transfer to the ward the patient arrested and needed to be resuscitated.

Upon investigation it was identified that there were a number of contributing factors to this event; multiple medical teams were involved in the care of the patient and there was no standard or consistent medical handover of the patient between the medical teams; the patient was not closely monitored, and the radiology unit was not staffed to allow for this level of monitoring.

In May 2005 the Australian Council for the Safety and Quality in Health Care, defined clinical handover as:

“Clinical handover refers to the transfer of information from one health care provider to another when:

- A patient has a change of location of care, and/or
- When the care of a patient shifts from one provider to another.”

What were the major contributing factors in this case?

- The patient had multiple medical teams looking after their care, and each assumed the other were aware of the patients condition

- Only minimal information was charted, due to pressure of workload and patient being transferred direct to radiology unit
- There was lack of clear and concise clinical information handed over to between the medical teams
- The radiology unit was not staffed to care for this type of patient

How did the health service address these issues?

- Developed a model of care for patients within the radiology unit
- Developed a policy and documentation on clinical handover
- Standardised handover process between all medical teams
- Ensure complex/high care patients are provided appropriate clinical escort when moving between clinical areas

How does your organisation manage clinical handover?

How does your organisation manage the movement of unstable patients within your organisation?

How does your organisation manage patients with multiple medical teams involved in their care?

Clinical handover

The Victorian Quality Council has recently undertaken a project on clinical handover.

The study identifies the barriers to effective clinical handover, and possible solutions to overcome them.

For more information go to the website at;

www.health.vic.gov.au/qualitycouncil/activities/handover.htm

RCA Education Modules

Work is currently being undertaken to pilot ‘Module Four – Incident Response and Review’, with a planned rollout of training in early 2007.

Module one and two are now available on our website at: www.health.vic.gov.au/clinrisk/

Lessons from the Sentinel Event Casebook continued...

Sentinel Event Report 2005-06

The sentinel event annual report was released to the media in early October. The final report is expected to be available on the DHS website during November.

www.health.vic.gov.au/clinrisk/index.htm

Potential for Error – Procedure involving wrong patient or body part

Despite positive development and implementation of policies and procedures aimed at reducing the risk of performing procedures on the wrong patient or body part, this area remains the dominant event reported to the sentinel event program. Fortunately most events are without catastrophic consequences to the patients. However such trends are cause for concern regarding the potential for risk escalation.

A number of events were reported in 2005-06 relating to the wrong patient being taken for x-ray, MRI or CT, the wrong body part being anaesthetised for surgery, aspirates and biopsies being attempted on the wrong side and procedures being performed incorrectly due to radiological images being labelled on the wrong side of the film.

What were the major contributing factors?

Communication between staff, failing to allow time out and checking prior to surgery, identification processes and issues associated with clinical guideline management, are recurring themes in nearly all events in this category.

In examining these themes, the sub issues that were acknowledged included

- Staff not having the confidence to speak out when concerns are identified
- Procedures continuing despite incomplete or inconsistent documentation, namely lack of consent forms and non updated surgery lists

- Reliance on short verbal handovers from staff and/or the patient themselves due to time constraints and workload
- The use of inappropriate markers for surgery such as felt tip pens that wash off or stickers that fall off
- Complacency and/or non adherence to 'time-out' protocols despite the existence of such safety net protocols

How did the health services address these issues?

- Implementation of 'Correct Site/ Correct Patient' protocols and education programs in all areas where interventional procedures occur. For more information go to www.safetyandquality.org/internet/safety/publishing.nsf/Content/home
- Review of the Porter/orderly/patient assistant role in identification and transportation of patients
- Review of avenues for increased use of electronic information systems such as the use of barcoding systems for patient identification
- Developing staff confidence, through 'speak out' programs
- Ensuring availability of indelible markers and that only senior staff who are fully briefed regarding the procedure, are to mark the patient (preferably those actually undertaking the procedure)
- Regularly monitoring for compliance to policy and procedures to ensure correct side/site/procedure and display results in staff rooms

Incident Information System (IIS) Project

The IIS project has progressed in the last three months and phase one 'scope and approach' is now finalised. It has been agreed that the project will focus on clinical incidents only 'events or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person receiving care.' OH&S and non-clinical incidents may

be explored in subsequent stages, but only once the reporting system is operational for clinical incidents.

Three key project objectives have been agreed:

- a) To develop a statewide, standard methodology for the way clinical incident information is reported within public health services.
- b) To implement a mechanism that will enable statewide aggregation, analysis and trending of multi-level clinical incident data.
- c) To establish appropriate mechanisms for departmental representatives and in-scope health services to evaluate the clinical incident data, identify trends and share relevant information such that quality improvements can be targeted toward problematic areas.

Phase two has commenced and will involve the development of a statewide data set and methodology for classification of clinical incidents. This activity will be conducted in collaboration with health service representatives from across the state to ensure the final methodology meets multiple needs.

Further information can be obtained from the IIS project website, available: www.health.vic.gov.au/clinrisk/iis or by contacting Danielle Whitman on 9096 8964 or danielle.whitman@dhs.vic.gov.au

Quote of the month

In order to change we must be sick and tired of being sick and tired.

Author Unknown

Risk Watch is produced by
The Quality and Safety Branch
Department of Human Services
50 Lonsdale Street
GPO Box 4057 Melbourne Victoria 3001
Telephone 03 9096 8558
email: riskwatch@dhs.vic.gov.au
Clinical Risk Management
website: www.health.vic.gov.au/clinrisk