

## Lessons from the sentinel event casebook

### Blood transfusion error

A patient received a blood product that had been cross matched and issued for another patient on the same ward.

The units of blood for 2 patients (Patient A and B) were collected from the transfusion laboratory. The blood was placed in an allocated area in the blood fridge in the ward. Nurse 1 collected the blood for Patient A from the blood fridge in the ward.

Nurse 1 and Nurse 2 checked the blood at the desk and ensured that the laboratory issue form and blood bag matched. Nurse 1 took the blood to the bedside of patient B and matched the patients ID band against the prescription form but not against the blood unit or the laboratory issue form. Nurse 1 started the transfusion.

Nurse 1 and Nurse 3 then commenced checking Patient A's blood at their bedside. The Nurses identified that the date of birth on the unit of blood did not match the DOB stated by Patient A. The blood infusing on Patient B was identified as incorrect and ceased.

The error was detected soon after commencement of the infusion and the patient received only 20-30mls of the incorrect blood. Fortunately the blood product was O negative (universal donor) and also met all of the patient's special requirements. There was no long term adverse outcome.

The error was detected during the pre transfusion checking procedure of blood products for the patient A.

#### What were the major contributing factors in this case?

1. The performance of a fragmented and incomplete pre transfusion blood checking process where identification on the blood unit, laboratory issue form and patient are not all checked together resulted in the incorrect patient receiving the blood product.
2. Collocation of multiple units of blood allocated to multiple patients within the satellite blood fridge on the ward facilitated the selection of the incorrect unit of blood.

#### How did the health service address these issues?

3. Pre transfusion checking processes in place on the ward be brought into alignment with the organisations procedure and best practice.
4. A procedure be established for the checking and recording of blood products being placed in and withdrawn from the fridge. This will also assist with the ability to evidence maintenance of the "cold chain" required for blood products.

### System improvement recommendations

The Blood Matters Advisory Committee discussed this event and two other similar recent events that all involved patient misidentification and the use of satellite blood fridges. The Advisory committee was concerned at this trend and felt that the potential risks of using satellite blood fridges should be highlighted to all hospitals and risk reduction strategies implemented.

### Retained instruments or other material after surgery requiring re-operation or further surgical procedure

A patient underwent surgery for ulcerative colitis. During the skin closure phase of the surgery it was identified by the instrument/scrub nurse that an artery forceps was missing in the final count. This information was communicated by the instrument/scrub nurse to the scout nurse and the members of the surgical team.

A thorough search of the theatre environment failed to locate the forceps. When the forceps could not be located, an x-ray was then taken of the patient, who had subsequently been transferred to recovery (as the patient had been extubated), which demonstrated the artery forceps in the abdominal region.

The patient was returned from recovery to theatre and forceps removed.

#### What were the major contributing factors in this case?

1. It was determined that a divergence from usual practice occurred when the patient was sent to recovery with an instrument still missing in the final count.
2. The Health Service had no formal written procedure to follow when count incorrect, to ensure all parties are notified and acknowledge incorrect count call.
3. Emphasis on where the forceps "couldn't be", rather than where they "could be" affected decision making.
4. It was unclear who had the authority to stop surgery in the event of an incident such as an incorrect count.
5. Allocation of staffing levels, resources and guidelines for decision making with reduced resources.

#### How did the health service address these issues?

1. It was agreed that it should be mandatory, that if the second count is incorrect, an x-ray is performed before patient leaves the operating theatre.
2. Formalise written procedure for incorrect count.
3. Formalise a nurse to surgeon ratio for larger cases with supporting written procedure.
4. Review of overarching policy that identifies the health service's capability to manage case types with the current staff skill mix, resources and infrastructure.

### The Pressure Ulcer Clinical Indicator Data Set

As an internationally acknowledged patient safety problem, pressure ulcers are increasingly recognised as an indicator of the quality of care provided. Pressure ulcers are a largely preventable adverse outcome of a healthcare admission. In the third Pressure Ulcer Point Prevalence Survey (PUPPS3) in 2006, Victoria's mean statewide prevalence was found to be 17.6%. This has reduced from the initial PUPPS1 survey in 2003 where the statewide mean was 26.5%. A comparable study in South Australia in 2007 showed a statewide pressure ulcer mean rate of 20.3%. ([www.safetyandquality.sa.gov.au](http://www.safetyandquality.sa.gov.au))

## Lessons from the Sentinel Event Casebook continued...

The Pressure Ulcer Clinical Indicator Data Set has been created to support ongoing surveillance of pressure ulcer occurrence. The data collection is based on recommendations resulting from PUPPS3 and consultation undertaken with health service representatives.

The Pressure Ulcer Clinical Indicator Data Set focuses on two key areas; number and severity of hospital-acquired ulcers and risk assessment of patients. These were chosen to provide the greatest value in a sustainable, relevant and achievable counting strategy.

Classification of pressure ulcer severity is based on the Australian Wound Management Association (AWMA) guidelines.

There have been two quarterly collections of data for 2008 and health services have received a report of their data and the statewide and peer group averages.

For more information:

<https://www.health.vic.gov.au/pressureulcers/puci.htm>

## Health Service Accreditation

The Statewide Quality Branch (SQB) has responsibility for verifying the accreditation status of Victorian public health services, and has worked with the Australian Council on Healthcare Standards (ACHS) in seeking an efficient way to do this without increasing the burden of reporting on health services.

The vast majority of health services in Victoria are accredited through ACHS. It is anticipated

that the SQB will receive an updated report from ACHS monthly, which will provide health service ratings against all criterion and a global statement in regard to their most recent survey, the SQB will not be receiving the complete accreditation survey report. This information will remain with the SQB and will not be made public.

This is seen not only as an efficient way to verify health service accreditation results but as a great opportunity to identify areas for improvement across Victoria's healthcare system.

## Australian Charter of Healthcare Rights

The Australian Commission on Safety and Quality in Health Care (the Commission) is pleased to announce that on 22 July 2008, Australian Health Ministers endorsed the Australian Charter of Healthcare Rights and its use as the pre-eminent healthcare charter for Australia.

The Charter, developed after wide consultation, specifies the key rights of patients and consumers when seeking and receiving healthcare services. These are Access, Safety, Respect, Communication, Participation, Privacy and Comment.

The purpose of the Charter is to provide information about the rights of patients and consumers to underpin the provision of safe and high quality care, and to support a shared understanding of the rights of people receiving care.

The Australian Charter of Healthcare Rights (PDF 45 KB) is now publicly available for download from the Commission's website.

<http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/home>

## Anticoagulation Therapy

At the Clinical Risk Management Reference group meeting in June 2008 there was a presentation from the Austin Hospital on work the Austin Pharmacy Department has done on anticoagulation therapy.

The presentation outlined the history to the work around the management of anticoagulation therapy, including:

- who is responsible;
- which pathology service is responsible;
- who knows the doses of *Warfarin*; ie, the when, why and how.

The management program has been rolled out to Austin's *Warfarin* service, and Pathology provider.

It is a very clear pathway of ongoing care. Pharmacy, pathology and discharge services are all involved and weekend discharge is an area that will be looked at over the next few months.

If you would like further information please contact us through the Riskwatch email address.

