

Lessons from the sentinel event casebook

Guardianship – Office of the Public Advocate

A patient under the guardianship of the Office of the Public Advocate (OPA) was admitted to hospital for elective surgery.

The patient consented to the surgery despite a guardianship order being in effect which included medical treatment. The patient's family had previously told medical staff that the patient was under guardianship for accommodation matters, not medical treatment.

The incident was discovered when the legal guardian called the ward post surgery to query why the patient was in hospital.

What were the major contributing factors in this case?

Medical and nursing staff did not have sufficient understanding in relation to guardianship matters, which resulted in a lack of understanding of the relevant requirements of guardianship orders.

There were inadequate prompts for staff to check the patient's status with respect to whether a guardianship order was in place on the admission and consent form, which may have increased the likelihood that consent for medical treatment was incorrectly obtained for this patient

How did the health service address these issues?

The health service combined three consent protocols into one document to improve understanding of the consent process in relation to competent and incompetent patients. Also included in the protocol was:

- Definition of a guardianship order
- Legal requirements associated with a guardianship order and consent process to follow
- A flowchart outlining the whole consent process

Education is to be provided to all nursing/medical staff on the new form.

The consent form was amended to ensure suitable prompts are included for the consenting practitioner to check the patient's guardianship status.

The admission process now includes a requirement for staff to specifically ask whether a guardianship order is in force. Where staff identify that a guardianship order is in force:

- An alert sticker is placed on orange alert form
- An electronic alert is used.

Does your health service have a process for enquiring about the guardianship orders of patients?

From the Office of The Public Advocate website:

<http://www.publicadvocate.vic.gov.au/>

Where staff have:

1. established that treatment is not an emergency, and
2. there is no relative or person responsible able to consent, and

3. are unsure whether there is an Order in place; its terms or its meaning... they should call VCAT during office hours on (03) 9628 9911. VCAT is the legal authority which grants guardianship orders to private guardians or the Public Advocate. After hours, you can call the Office of the Public Advocate on its 24-hour contact line 1300 309 337.

What if the person who needs treatment cannot give consent?

Consent is not required for emergency treatment. If a patient cannot consent to their own treatment, the practitioner can obtain consent from the 'person responsible'.

If there is no person responsible, the dentist or medical practitioner must submit a **Section 42K Notice** to the Office of the Public Advocate.

Similarly, a person responsible can consent to a medical procedure for the purposes of medical research. However, if there is no person responsible, the practitioner must submit a **Section 42T Certificate** to the Office of the Public Advocate.

Find out more: Visit the Office of the Public Advocate website at www.publicadvocate.vic.gov.au and follow the medical consent links to fact sheets, flow-chart guides and notice forms. Or call the OPA Advice Service on 1300 309 337.

Mental Health – Absconding patient

A patient was admitted to an Adult Acute Inpatient Unit, as an involuntary patient due to exacerbation of their depressive illness. They had a past history of psychiatric treatment from an early age and had also received additional support through a general practitioner. It was this general practitioner who had referred them to the emergency department of the local hospital for assessment and admission. The consumer was seen by the Enhanced Crisis Assessment Treatment Team (ECATT) and then referred to the local Primary Mental Health team due to escalated agitation, distress and suicidal ideation without a clear plan.

The primary mental health team managed them for a month until they were referred to Crisis Assessment Treatment Team (CATT) due to their risk of self-harm.

During their admission to the inpatient unit the consumer displayed major shifts in presentation and clinical features. Their management plan evidenced a range of clinical interventions including high dependency, use of PRN (pro re nata – as needed) medication, changing observation levels and alterations in medications. They were taken off section and remained within the service as a voluntary patient. Five days later they presented to staff in the morning complaining of suicidal ideation.

At this point they were given PRN medication and asked to stay in the lounge area to be observed. In the afternoon family and friends visited. The consumer accompanied them for a coffee at the hospital café, returning to the ward mid afternoon.

After returning from the cafe the patient's mother approached staff, expressing concern about their mental state and suicidal ideation.

Lessons from the Sentinel Event Casebook continued...

The patient was spoken with and offered strategies including music, art and relaxation techniques.

The patient was found to be missing later in the day. They had not informed staff of their intention to leave the unit.

Approximately an hour later, the surgical registrar from the emergency department (ED) called the Unit and informed nursing staff that the patient had been brought to the ED via ambulance having reportedly jumped from a nearby building.

The registrar stated that they had sustained multiple fractures but were in a stable condition.

What were the major contributing factors in this case?

The assessment of the patient did not identify their high risk of suicide. This arose from the clinician's difficulty in engaging with them due to their fluctuating symptoms and the prolonged initial assessment. The significance of their agitation was also not recognised, as they were not previously known to the service. The patient had also been agreeable to the management plan and had engaged in ward programs.

A lack of awareness of the importance of monitoring and documenting a patient's changing level of risk meant that the risk assessment form was not completed in accordance with clinical guidelines. This impaired the ability of clinicians to recognise the significance of changes in the patient's behaviour.

How did the health service address these issues?

Up-skilling of staff on the assessment of risk through clinical training with particular reference to the significance of agitation, the higher risk of unknown patients and the importance of information provided by family and relatives.

Development of a unit specific education program that highlights these key risks and consideration of a rollout across service.

Inclusion of a prompt to assess and rate the level of agitation within the risk assessment form.

Embed a weekly review of PRN medication in ward round.

Provision of regular education sessions to staff by the carer consultants on engaging and listening to carers and family members.

Implementation of a minimum of twice-weekly review of consumers risk assessment.

Does your health service have a process for engaging carers?

Do you assess and rate the level of agitation in consumers?

TGA Alert PICC lines

The Therapeutic Goods Administration has investigated reports of adverse events associated with the use of Peripherally Inserted Central Catheter (PICC) lines in Queensland. The reports followed an initial investigation of an incident involving a 5 year old child at Townsville Hospital.

On 7 October 2008 the Therapeutic Goods Administration (TGA) received a preliminary adverse event report from a hospital in Queensland of an incident that occurred during a procedure to insert a peripherally inserted central venous catheter line, commonly referred to as a PICC line. The TGA has subsequently received a number of additional reports from Queensland of similar events associated with the use of the device made by Arrow International Inc.

The TGA regarded these reports as serious and investigated them as a matter of urgency. The TGA liaised with Queensland Health on the issue as well as with other international regulatory agencies to determine whether this is a worldwide issue.

As an interim measure the Australian sponsor of the Arrow product (Mayo Healthcare) undertook a Recall for Product Correction to update the Instructions for Use supplied with the catheters.

The TGA also investigated other brands of PICC devices in the Australian market to determine whether the issues raised in the incident reports are relevant to other brands of catheters.

This investigation has now been completed. The results of this investigation have shown that there are no inherent flaws in any of the PICC lines. However, as with all medical devices it is important that Instructions for Use are carefully followed. The TGA has identified opportunities for improvements that can be made to the current label warnings and Instructions for Use accompanying all of the devices. The TGA believes that such improvements will assist users of the devices and has requested the sponsors of the devices to undertake these changes.

www.tga.gov.au/alerts/devices/picc3.htm

Oral Chemotherapy NHS alert

A patient with an aggressive brain tumour (glioblastoma multiformae¹) was prescribed a high dose of oral chemotherapy (temozolomide oral, 350mg, once daily) to be taken for 5 days followed by a 23 day rest period.

This cycle was to be repeated 5 times. (i.e. 6 cycles x 28 days each cycle; consisting of 5 days of medication and 23 days without).

After obtaining the original prescription, the patient re-presented four times at Pharmacy and was dispensed a repeat prescription over a 26 day period without staff recognizing the patient was not applying the 23 day rest period.

The error was recognized when the patient contacted his neuro-oncology consultant for a new prescription after taking 25 doses over 31 days. The Consultant would not be expecting to re-issue a new prescription for at least 24 weeks.

Following recognition of the overdose, the patient was administered pegfilgrastim a G-CSF (granulocyte-colony stimulating factor), to stimulate bone marrow production of white blood cells as he was at high risk of becoming neutropenic as a result of the overdose.

The patient survived another 6 months and his subsequent death was not deemed related to this incident.

What were the major contributing factors in this case?

The patient self-administered an overdose of oral chemotherapy because he did not clearly understand the dosing regimen and because the repeat prescriptions were dispensed within a 5 – 8 day timeframe rather than a 28 day gap.

How did the health service address these issues?

- Developed formalised guidelines on what education is to be provided to oncology patients undertaking drug regimens as outpatients. These included recommendations around re-iterating the most crucial information for patients, possibly by highlighting / marking the most crucial information in the patient education materials provided.
- Map out the dispensing process and include a checklist of steps required at each stage in the dispensing chain (inclusive of both original and repeat dispensing).

¹ The most common and aggressive type of primary brain tumour. Treatment of primary brain tumors and brain metastases consists of both symptomatic and palliative therapies. The median survival time from the time of diagnosis without any treatment is 3 months, which increases to 14 months with standard treatment. The 5 year survival rate is measured at less than 3%.

Lessons from the Sentinel Event Casebook continued...

- Developed a proforma letter to be handed to any person picking up medication on behalf of an outpatient, recommending the patient contact the pharmacy for clarification of drug regimen.
- Developed an education package to inform medical staff of their responsibilities under the prescribing guidelines. The full dosing regimen was not included on the prescription (dose included but 'rest period' omitted) because some consultants may view the writing of a prescription as an order for supply of drugs rather than a description of how drugs to be taken; and because medical staff may not be aware of the lack of access by pharmacists to treatment plans or indication as to why drugs have been prescribed, leaving pharmacists to deduce gaps in dispensing details, and undertake some follow-up audits to measure improvement.
- Introduced the requirement that all oncology scripts to be reviewed by an oncology trained pharmacist.
- Reviewed orientation program and materials provided to new pharmacists at health service and annual internal training program to assist pharmacy staff members expand knowledge base and competency.
- Introduced another 'checking step' into oral chemotherapy dispensing, requiring the patient to have their white blood cell counts measured and given approval from the medical team before proceeding to their next repeat.

What else can be done in health services?

- Plan for future electronic prescribing systems (ie Health Smart) and emphasise the need to build in safety nets for the prescribing and dispensing of high risk drugs.

The National Patient Safety Agency in the UK issued an alert in January 2008 on oral chemotherapy.

The National Patient Safety Agency (NPSA) is alerting all healthcare staff involved in the use of oral anti-cancer medicines of potentially fatal outcomes if incorrect doses of these medicines are used. These oral anti-cancer medicines are increasingly being used in hospitals and in the community.

Risks are increased if non-specialist practitioners prescribe, dispense or administer these oral medicines and bypass the normal safeguards used for injectable anti-cancer medicines. For further information refer to the website.

www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr/risks-of-incorrect-dosing-of-oral-anti-cancer-medicines/

Another case for the introduction of oral dispensers – VMAC update

Following the VMAC (Victorian Medicines Advisory Committee) release of the Wrong Route Alert in February 2008, there has been a reported take up of oral dispensers by only 33 health services of a total 88 health services in Victoria.

VMAC would like to draw your attention to another Victorian sentinel event resulting from the inadvertent administration of five oral liquid medicines via a central venous line which has occurred after the release of the Wrong Route Alert. While many factors contributed to the incident, this case highlighted the importance of the use of oral dispensers for the administration of oral liquid medicines rather than standard parenteral syringes. Oral dispensers have been designed to not connect to parenteral lines which would have averted this incident. The health service involved in this incident has since introduced oral dispensers.

Risk Watch is produced by
The Statewide Quality 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