

Risk Watch

Volume 7, issue 1 – 2009

Lessons from the sentinel event casebook

Subdural haematoma after fall

An elderly patient with abdominal pain was admitted to the local hospital via the Emergency Department from a nursing home. The provisional diagnosis was a small bowel obstruction and the patient was admitted to the ward for further investigation.

A falls risk assessment was performed as part of the normal admission process, and the patient was noted to be a high falls risk. It was also noted that the patient was sometimes slightly confused.

On the fourth morning after admission the patient was found on the floor at the end of the bed. The patient had a bleeding laceration to the back of the head.

Nursing staff commenced neurological observations, applied a pressure bandage and the patient was physically assessed by the surgical doctors later that morning.

The decision was made to continue with a radiological procedure that was booked to investigate the bowel obstruction that morning. This procedure was undertaken without incident.

Over the following days the wound failed to stop bleeding and was sutured. It was documented that the patient on at least one occasion had a fluctuating conscious state, but other times was noted that they were orientated and comfortable. Four days after the fall the patient became extremely confused and agitated and a CT (computed tomography) scan of the brain was ordered.

The scan showed a large subdural haemorrhage and the patient was transferred to a tertiary hospital for further assessment and treatment.

The patient returned to the original hospital for palliative care two days later, after the decision was made not to pursue surgical options.

How did the health service address these issues?

- A full review of current documentation systems was undertaken to ensure seamless patient care.
- Monthly audits of the Falls Risk assessment forms are undertaken in all clinical areas, particularly focusing on follow up assessments and strategies documented.
- Review of the Falls Prevention policy to include steps to be taken after a fall, and observation requirements in suspected or actual

head injuries. Education of staff in same. Monitoring via incident reporting system.

- Re – introducing of the x-ray handover slip to accompany patients to radiology to provide radiology staff with current relevant patient information.
- Guidelines to be developed, with subsequent education for clinical staff that outlines thresholds for routine CT Brain following falls with head injuries.

What have other services done regarding falls?

- Improve patient identification for falls risk at the ward level by ensuring that an electronic alert is generated on the medical record and by other means of communication including staff education sessions e.g. mandatory update and orientation.
- Provide education regarding the content and necessity for compliance with the current Patient Falls Prevention Policy.
- Investigate methods of improving communication and coordination between health disciplines (medical/nursing/allied health) in relation to falls prevention.
- Provide in-service education to all nursing staff regarding neurological observations and the use of the Glasgow Coma Scale.
- Review Emergency Department assessment procedures and documentation to ensure falls history/risk is captured and appropriate action taken.
- Explore the feasibility of developing guidelines for the escalation of clinical matters to senior staff, both in and out of hours, and implement guidelines as indicated.

Does your health service have a process for auditing of falls risk assessments?

Cataract Surgery – wrong lens

An elderly patient presented for right eye cataract operation. The patient was in pre-block (pre-anaesthetic) when the registrar attended to determine the intraocular lens (IOL) power required for surgery. The registrar referred to the patient's A-scan. (The A scan is a biometric scan which measures the axial length of the eye and the curvature of the cornea and is integral to determine the appropriate intraocular lens).

An annotation that the eye was amblyopic (lazy eye) was written across the A-scan results for the right eye. The registrar referred to the

Lessons from the Sentinel Event Casebook continued...

left eye results on the A-scan (incorrect eye) and selected the power required. The patient proceeded to operation which was uneventful.

At the one week follow-up appointment, it was discovered that the incorrect power lens had been inserted during surgery. Arrangements were made for the patient to undergo additional surgery for the correct power to be inserted. This was fully disclosed to the patient and family.

What were the major contributing factors in this case?

- The annotation on the A-scan led to confusion and resulted in the registrar selecting the IOL power for the incorrect eye.
- The lack of documentation regarding the clinical decision for the choice of lens increased the probability for an incorrect lens to be selected.
- As team time out did not include confirmation of the IOL power required, there was no opportunity for the team to identify that the incorrect lens had been selected, which led to the incorrect IOL being inserted for surgery.

How did the health service address these issues?

- A written response was required from the Ophthalmology Unit regarding the assessed risk to the organisation of continuing to use different A-scan reports.
- Ophthalmology Unit to implement a process whereby the IOL selected for surgery is documented within the patient's medical record or consent form.
- Team Time out prior to insertion of an IOL must include a check of the A-scan and that the correct IOL power has been selected.

Does your health service have a process for time out in ophthalmic surgery?

Between August 2005 and April 2008 there have been 10 Sentinel Events reported that involved wrong site eye surgery.

Five Sentinel events involved the wrong eye being anaesthetised. Two events were surgery performed on the wrong eye, two involved the wrong size lens being inserted and there was one near-miss where surgery was consented for the wrong eye.

The guidelines issued by the Victorian Surgical Consultative Council http://www.health.vic.gov.au/__data/assets/pdf_file/0007/266569/correct_side.pdf reiterate the importance of marking the correct site and side and ensuring the correct prosthesis is selected.

What is included in a Root Cause Analysis (RCA) Report to the Department of Human Services?

There has been a gradual change in the content and quality of information provided to the department by some health services.

It is important to have consistency in reporting to ensure that the RCA is being conducted thoroughly and that the health service has addressed all the issues. This also allows for other services to benefit from the learnings through this newsletter and health alerts. The information on what is required and the format for the RCA report is available on the website at:

<http://www.health.vic.gov.au/clinrisk/sentinel/rca.htm>

What is RCA?

RCA is a process analysis method, which can be used to identify the factors that cause adverse events. The RCA process is a critical feature of any safety management system because it enables answers to be found to the questions posed by high risk, high impact events—notably, what happened, why it occurred, and what can be done to prevent it from happening again.

Risk managers and other health care personnel use RCA analytical methods to investigate ('drill down' into) serious incidents (including near misses) to identify the underlying causes and to guide solutions to address safety system failures.

When should RCA be undertaken?

RCA is normally only performed on high risk, high impact events, such as sentinel events.

The RCA process should not be performed for incidents involving criminal acts or requiring disciplinary action.

Major steps in a RCA investigation

The major steps in a RCA investigation are:

- verify the incident and define the problem
- commission the RCA investigation
- map a timeline (event and causal factor chart)
- identify critical events
- analyse the critical events (cause and effect chart)
- identify root causes
- support each root cause with evidence
- identify and select the best solutions
- develop recommendations
- write and present the report.

Each health service should have a number of persons trained to undertake RCAs according to the approved department training. If you would like more information on the training, please contact the department via telephone or email as below.

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