

Risk Watch

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Lessons from the sentinel event casebook

Potential for error

– Wrong eye block for cataract surgery

An elderly patient was admitted to the day procedure unit for cataract surgery to the right eye.

The admitting nurse completed the admission paperwork and the initial patient assessment. They discussed the procedure with the patient, checked the consent form, placed a dot above the patient's right eye and then administered eye drops to dilate the right pupil. The nurse then went to the other side of the room to complete their other tasks of checking equipment and preparing procedure trays.

The anaesthetist attended the patient and administered a sedative, as they appeared anxious. The anaesthetist then asked the patient to point to the eye that was to be operated on. However, the patient pointed to their left eye and the anaesthetist proceeded to anaesthetise the left eye.

The patient was transferred to theatre and during 'time out' it was noted that the pupil had not reacted as expected. The surgeon was informed immediately. After a brief discussion with the patient, the anaesthetist went on to block the correct eye so that the surgery could continue.

As a result the patient's stay in the day procedure centre was extended by several hours. The patient was extremely upset by the event and claimed that she had not really understood what had happened until the Nurse Unit Manager had explained the error in more detail after the surgery was completed.

What were the major contributing factors in this case?

- Sedation had been administered prior to confirming site of surgery.
- The anaesthetist relied on the patient only to confirm the site of surgery. The side identification dot was not noticed.
- The admitting nurse who had administered the initial eye drops had not followed the patient through to theatre.

- The unit was busy with the admitting nurse required to undertake multiple tasks.
- The surgeon had a busy surgical list scheduled and time restraints prevented adequate discussion with the patient at time of error identification.

How did the health service address these issues?

- 'Time Out' protocol ensured that the error was identified and corrected prior to commencement of surgery. However the organisation reviewed its surgical and identification procedures relating to correct patient, site and side.
- The organisation reviewed the need for a protocol and communication tool relating to open disclosure of adverse events in adherence with the National Open Disclosure Standard.

How does your organisation communicate adverse events with patients?

What are your organisation's procedures for ensuring correct patient, side and site for surgery and how effective are they?

National Open Disclosure Standard

Ongoing improvements in the safety and quality of our health care system are dependent on the proactive and timely management of adverse events.

The Australian Commission for Safety and Quality in Health Care (formerly the Australian Council for Safety and Quality in Health Care) recognises that a key step in that management process is encouraging greater openness around adverse events.

This involves acknowledging when things go wrong, providing explanations to those involved and providing reassurance to patients and their carers that actions will be taken in order to prevent a recurrence of such events.

The Open Disclosure Project is an initiative of the Commission that is aimed at enhancing communication at the point of care and, ultimately, leading to safer health care

Lessons from the Sentinel Event Casebook continued...

The Commission has developed an 'Open Disclosure Standard: A National Standard for open communication in public and private hospitals, following an adverse event in health care' and a 'National Open Disclosure fact sheet'.

For more information go to www.safetyandquality.org/index.cfm

Ensuring Correct Patient, Correct Site, Correct Procedure

The Australian Commission for Safety and Quality in Health Care (the commission) has worked with the Royal Australasian College of Surgeons (RACS) and the States and Territories to develop a protocol for the prevention of procedures performed on the wrong patient or part of the body. The protocol is in line with the RACS Correct Side and Correct Site Surgery Guidelines.

In 2005-06 the Department of Human Services requested that all health services expand the protocol to all areas where patient undergo procedures, such as in radiology, pathology and day procedure areas.

For more information go to www.safetyandquality.org/index.cfm

Potential for Error – Incorrect use of an air mattress

An obese and confused patient had been admitted for assessment; initially the patient was agitated and verbally aggressive. The patient was given sedation to calm them down.

The patient was assessed as at risk for developing pressure ulcers due to their obesity and sedation. An air mattress was placed on the patient's bed to reduce this risk.

After lunch, the patient had been checked by the morning nurse and was found to be calm and responsive. Shortly after handover, the afternoon nurse went to introduce themselves to the patient and found the patient tangled in the cot side with their head wedged between

the mattress and sides. The patient had stopped breathing. They were immediately released and successfully resuscitated.

What were the major contributing factors in these cases?

- Environmental Risk – the air mattress had not been designed for that particular style of bed and had different dimensions to the base of the bed. There were gaps between the air mattress and the cot sides and the air mattress was thicker/higher than normal.
- Lack of Staff Awareness – staff had not been aware of the environmental risk created when combining the use of that particular style of air mattress and cot sides.

How did the health services address these issues?

The mattress was immediately removed from circulation and the supplying company notified.

The hospital reviewed its pressure care procedures with particular emphasis on equipment compatibility.

An environmental risk awareness program regarding equipment use was established.

Are the staff in your organisation aware of the compatibility of different types of equipment?

Update on Sentinel Event Program

A number of enquiries have been made regarding the definition of the sentinel event category 'other catastrophic'.

'Other Catastrophic Event' refers to any incident (actual or near miss) that does not fall into any of the other eight Sentinel Event categories. If risk rated it would meet the Incident Severity Rating (ISR) of 1.

The severity or consequences of an incident can be divided into four categories, which correspond

to an appropriate level of management response. These levels are:

- ISR 1 – executive management response
- ISR 2 – senior management response
- ISR 3 – line management response
- ISR 4 – line management response.

The following guidance on how to classify incidents is intended as a suggested starting point when determining which incidents will be the subject of an RCA investigation. This guidance is not intended to cover all possible scenarios, but illustrates a range of typical harm related outcomes.

Near miss incidents will require judgment to determine the potential safety value (organisational and industry-wide lessons) to be gained from conducting an RCA investigation. If an event could be characterised by more than one rating, apply the higher rating.

ISR 1

Relatively infrequent, clear-cut events which occur independently of a patient's condition, commonly reflect hospital system and process deficiencies, and result in or have the realistic potential to result in an unexpected death or a permanent disabling injury or psychological harm to a person, and include reportable sentinel events

For further information regarding the reportable sentinel events and the sentinel event program go to www.health.vic.gov.au/clinrisk/

Quote of the month

"The greatest obstacle to discovery is not ignorance – it is the illusion of knowledge"

Daniel J. Boorstin (1914 -)

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