

# Risk Watch

March/April 2007 – volume 5, issue 3

## Lessons from the sentinel event casebook

### Alert – Medical Emergency Team (MET) criteria and initiation of call

The Department of Human Services (the department) has recently reviewed a number of sentinel events that highlight a number of issues around the Medical Emergency Team (MET) process, and an uncertainty about when and where it should be activated. The intent and purpose of a MET is to respond to cases in a more controlled environment, before they become resuscitation calls. The initiation of a MET call needs to be in a timely and appropriate manner, with staff involved being supported in calling a MET.

The reports reviewed all had an element where cases meet the MET criteria but a MET call was not made until the situation became a full resuscitation. In some instances staff felt they were ‘frowned upon’ for initiating the MET call, despite patients meeting the physical criteria.

Where services introduce a MET response, it is important that they meet the needs of the organisation, and there are criteria for all specialty areas provided by that health service, for example paediatric and midwifery.

### Has your organisation evaluated its MET protocol in regard to its appropriateness of criteria and effectiveness of utilisation?

#### Potential for Error – Vascath return line disconnection

A patient was admitted to an Intensive Care Unit (ICU) diagnosed with endocarditis (inflammation of the heart muscle). The patient was sedated and a vascath (a special intravenous catheter) was inserted to allow for haemodialysis. Shortly after the patient had been repositioned for their pressure care they became agitated and acutely unstable and when the bed sheet was pulled back it was found that the intravenous line had become disconnected. The patient had

bled from this line and lost approximately 3 litres of blood into the bedding. The patient was immediately resuscitated with fluids, including blood.

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

- Failure to check leur lock connections following patient repositioning resulted in undetected disconnection and associated major blood loss.
- The haemodialysis equipment to which the line was connected failed to alarm. After the event, the equipment was cleared of its memory and removed from use, for assessment and service by an appropriately trained technician.

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

- A protocol was developed for the checking of connections for all infusion lines following significant patient repositioning.
- A protocol was developed detailing the processes for dealing with suspected faulty equipment including removal from service and data retention.
- The supplier and manufacturer of the equipment were notified and they, in turn, notified the Therapeutic Goods Administration (TGA).

### Does your organisation have a protocol for managing potentially faulty equipment?

#### Potential for Error – Retained Instrument

A patient was admitted through the hospital’s elective surgery stream for a total hip replacement. Following the uneventful surgery the patient was transferred to a ward for their post-operative recovery.

Shortly after, the Central Sterilising Unit (CSU) Technician contacted theatre staff to inform them an instrument pin was missing. The surgeon was advised, and an x-ray was performed which confirmed the measuring pin had been left in the patient. The following day the patient returned to theatre to have the pin removed.

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

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

- The orthopaedic measuring pin was not included in the instrument count at the commencement of surgery
- The design of the hip prosthesis required the pin to remain in place for the duration of the surgery as there was no alternative measuring tool
- Staff were unfamiliar with the prosthesis as only a handful of cases had been performed using the device previously
- The company representative who had been present in theatre at the request of the orthopaedic team, had left prior to the surgery being completed

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

- The instrument count protocol was altered to include all orthopaedic loan kit equipment
- The instrument company was advised of the incident

### What processes are in place in your hospital for the tracking of loan equipment?

#### Incident Information System (IIS) Project Update

Phase two 'Data Set Development' is almost complete. The IIS Project Advisory Group has been using a variety of local, national and international reference sources to derive the core components of the reporting data set, including definitions. The core data set has been finalised, and will be released via a series of workshops, to ensure it meets multiple needs across all service types. The full data set is due for delivery by 30 June 2007. The project will then explore functional capabilities to determine the optimal statewide implementation approach.

For additional information regarding the Incident Information System (IIS) please

contact Danielle Whitman, IIS Project Manager on 9096 8964 or email [danielle.whitman@dhs.vic.gov.au](mailto:danielle.whitman@dhs.vic.gov.au)

#### Victorian Maternity Services Performance Indicators

Maternity Services at the Department of Human Services has published its 4th annual statewide performance indicator report for public hospitals providing maternity services.

Since 2003, all Victorian public hospitals providing maternity care have been reporting a suite of 10 performance indicators focused on process and outcome measures across the continuum, from pregnancy through to the early post natal period. The report enables hospitals to benchmark outcomes with similar-sized services and analyse trends within their own service. The Victoria Maternity Services Performance Indicators – Complete set for 2005-06 and previous reports can be found at [www.health.vic.gov.au/maternitycare](http://www.health.vic.gov.au/maternitycare). For hard copies please contact Sabrina D'Cruze at [Sabrina.D'Cruze@dhs.vic.gov.au](mailto:Sabrina.D'Cruze@dhs.vic.gov.au)

#### STIR – Serious Transfusion Incident Reporting system

The Better Safer Transfusion (BeST) Serious Transfusion Incident Reporting (STIR) system was piloted during July – October 2006 to capture serious hospital transfusion incidents, including near misses. During the pilot there were a total of 42 reports of serious adverse transfusion events reported. Significantly, 43 per cent of the reports were due to procedural problems that had the potential to cause serious harm. As a result of the data collection and subsequent hospital-based review processes, health services have already begun introducing additional safeguards and practice improvements in the management of blood products and transfusion practices. This statewide data will enable the BeST program

to make recommendations for improvements for safer transfusion practice. The STIR program is currently being implemented across Victorian metropolitan and rural health services. For more information contact Lisa Stevenson or Karen Botting at the BeST program on 9096 0476 or visit [www.health.vic.gov.au/best/](http://www.health.vic.gov.au/best/) for an overview of the BeST program.

#### Root Cause Analysis (RCA) – Module 4 Training

The department commenced delivering Module 4 training, focussed on clinical case review, in Melbourne on 11 May 2007. The training consists of one-day train the trainer workshops. The workshops are designed to provide health services with trained facilitators in clinical case review. The training is most beneficial for quality and risk management leaders who are able to take on the role of educator within their service, and assist others in developing their skills. Regional workshops are planned over late May and early June.

If you have any queries regarding the above, contact Mr Deane Wilks on 9096 7916 or via email at [deane.wilks@dhs.vic.gov.au](mailto:deane.wilks@dhs.vic.gov.au).

#### Quote of the month

"Health is a large word. It embraces not the body only, but the mind and spirit as well..."

*James H. West*

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