Risk Watch

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Lessons from the sentinel event casebook

Potential for error – communication issues

A rural patient with a chronic medical condition required transfer to a metropolitan hospital for ongoing management, including surgery that would relieve some of the patient's current symptoms.

Arrangements between the two hospitals were made. The transfer took place four days later on a Saturday morning. The patient was admitted directly to a general surgical ward.

The on call surgical resident admitted the patient and a treatment plan was developed, ordering baseline investigations and some specific to their condition, to prepare the patient for surgery.

The consultant saw the patient on the Monday morning and the treatment plan was reviewed. This was due to the patient's deterioration prior to transfer from the rural hospital.

Subsequently a procedure to relieve congestion of fluid on their lungs was performed on the ward. During this procedure there was a complication where the lung wall was accidentally punctured and the patient developed a pneumothorax (air in the wall cavity which reduces the function of the lung).

The patient required a more intensive treatment plan due to their worsened condition on admission and unfortunate (but a known) complication of the pneumothorax.

What were the major contributing factors in this case?

- The patient's condition worsened whilst waiting for transfer. This vital information had not been provided to the receiving hospital.
- Following the patient's admission the junior surgical resident did not discuss the patient's management plan with the consultant on call.

How did the health service address these issues?

- Admission processes were reviewed to ensure appropriate documentation, clinical handover and medical triage occurs for all inter unit/hospital transfers.
- Better communication between referring hospitals was included in the above review, and included no elective transfers occur 'after hours' unless patients condition dictates otherwise.
- Education of junior medical staff to communicate with senior medical staff condition of patients admitted under their care.

What does your organisation do to prevent this event or similar occurring within your health services?

Does your hospital/health service communicate/document accurately patients condition when inter unit/hospital transfers occur?

Dental Health Services Victoria (DHSV) engage in Victorian Sentinel Event (SE) Program

There has been discussion and commitment from DHSV to participate in the department's SE program. It has been agreed that all services, both acute and community managed by DHSV, will report to the Department of Human Services SE program.

How will this work?

- All services, both acute and community, managed by DHSV, participate in the Victorian Sentinel Event Program.
- All SE's that occur in public dental health agencies managed by health services will be forwarded to DHSV in the first instance and then on to Office of Chief Clinical Advisor, (OCCA).
- All SE's (Category 1 Critical Incidents) that occur in public dental services managed by community health centres will report adverse events through DHSV's critical incident reporting process and forward a copy of the report to DHSV.
- All documentation will remain consistent with current Department of Human Services SE program requirements.
- Department of Human Services reporting timelines remain unchanged. Refer to www.health.vic.gov.au/clinrisk
- Where there are system lessons to be learnt from the root cause analysis and risk reduction plans, DHSV and OCCA will liaise with the dental health program to disseminate to the wider dental community.

Victoria
The Place To Be

Lessons from the Sentinel Event Casebook continued…

Focus on contributing factors continued…

Each root cause analysis identifies the contributing system factors that impacted on the event'soccurrence. For more information see the Sentinel Event Program Annual Report 2003-04 www.health.vic.gov.au/clinrisk/sentin.htm#anrep0304

Below are 'themes' identified from recent sentinel events reviewed by the Clinical Risk Management Reference Group.

Procedures and guidelines

Many health services have infusion pumps (used to run IV fluids/drugs within set limits) that perform different levels of function, ie some are 24 hour pumps, some are only 1 hour pumps, some are patient controlled, and others are adjustable to perform many uses. In this sentinel event, a patient received 45mgs of pethidine over 30 minutes instead of over 24 hours, when connected to a multi dose rate pump instead of the standard 24 hour rate pump.

Two nurses checked the preparation, but only one took the medication to the patient and connected the infusion pump.

The main issues identified were related to various infusion pumps being available in the unit, and staff not following standard policy related to medication.

Action plan

- standardise equipment – removal of all other infusion pumps within the area
- Re-inforce medication policy re double checking, and the overall five rights – right patient - right drug - right dose - right route - right time/frequency
- educate and train staff in the use of equipment and functions they perform.

Does your organisation have a documented medication policy, and do you monitor compliance to this policy?

Does your organisation attempt to standardise equipment to reduce potential for error?

Does your organisation provide competence based education related to equipment such as infusion pumps?

News updates

Department of Human Services Sentinel Event Program

Did you know that if your Health Service has an aged care/residential unit as a component of the Health Service, that you should be reporting serious adverse events to the department sentinel event program?

The Australian Council for Safety and Quality in Health Care (the council)

- The council is currently undergoing a review of its function and future directions. Go to www.health.gov.au/internet/wcms/publishing.nsf/Content/health-sqreview.htm for the full report.
- By the end of 2005 the council will require all public hospitals to report all sentinel events, and to contribute to a report. This will be based on the Joint Council for Accreditation Organisation list of Sentinel Events, (Victoria will continue to report other catastrophic events).
- In an effort to develop some common language and consistency in describing activities related to safety and quality, the council agreed to develop a vocabulary of key safety and quality terms. They will be used to define terms in current council projects and publications. See www.safetyandquality.org/articles/action/definitions.pdf
- 3rd Australasian Conference on Safety and Quality in Health Care 11–13 July 2005, Adelaide Convention Centre South Australia - **Evolution or Revolution!** For more information visit www.sapmea.asn.au/conventions/aaqhc2005/index.html

National Health Service (UK) update

The NHS has developed safety advice on nasogastric tubes (NGT). This update discusses tests used to ensure right positioning of NGT's, and makes recommendations regarding tests to be used, and those currently in use, which should be stopped immediately. See www.npsa.nhs.uk/health/display?contentId=3550

Article of interest

The Joint Council for the Accreditation of HealthCare Organisations has released its National Patient Safety Goals for 2005/2006 – these are most applicable to health care services in Australia and make for an interesting read, for further details go to www.jcaho.org/accredited+organizations/patient+safety/npsg.htm

Quote of the month

"Don't be afraid to ask dumb questions. They're more easily handled than dumb mistakes."

William Wister Haines

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