Risk Watch

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Lessons from the sentinel event casebook

Potential for error – procedures/guidelines

A patient underwent an operation for a left total knee replacement. The nurse prepared the medical records and notes to accompany the patient back to the ward. The documentation noted that labels from the prosthesis used were for a right knee prosthesis set. The patient was returned to theatre and the components were replaced with the appropriate set.

The patient required further surgery, an extended anaesthetic, and had a prolonged postoperative recovery.

What were the major contributing factors in this case?

The investigation found that there were a number of factors that contributed to this event, including:

- Procedures/guidelines were not followed:
  - surgeon and nurses did not complete 'time out' and check that components were for the correct side/site
- Communication:
  - there was no discussion between the surgeon and scout nurse as to what side surgery was being performed on.
- Component packaging:
  - labels were small and the markings for left and right were not clearly marked
  - the wrapping obscured some of the printing on the label.
- Human Resources:
  - the scout nurse was in charge of the theatre unit and was also managing staff and reception.
- Storage of component sets:
  - both left and right component sets were kept on the same trolley. This was taken into theatre and staff selected appropriate side components in theatre.

How did the health service address these issues?

- Discussions were held with the manufacturer to improve packaging so that labels are clearly identifiable. The manufacturer has since changed labelling.
- The importance of time out was reinforced, as was correct side/site protocol. This ensures all staff are aware of correct procedure, site and equipment required.
- Storage was changed so that only the correct side/ components go into the theatre for each procedure.
- When staff allocated to in-charge role, they do not take a clinical load.

How does your organisation manage incidents related to correct side/site?

The Royal Australasian College of Surgeons, and the Victorian Surgical Consultative Council have produced a set of guidelines to assist all operating theatres address this type of issue. Titled 'Component Selection Practice' these guidelines can be found, under 'what's new' at www.health.vic.gov.au/vscc/index.htm

Patient identification/coordination of care

A patient was sent to radiology to have a fluoroscopic procedure (a technique for obtaining 'live' X-ray images and often used to observe the digestive tract).

The radiographer was waiting for two patients of the same age and sex to have chest x-rays. The first patient arrived and was taken straight into the procedure room and underwent a fluoroscopic procedure and chest x-ray. At no time did the radiographer positively identify the patient against the radiology request. The patient was unfamiliar with the process

Root Cause Analysis (RCA) Education Program - Update

Education in Module 3 continues and the last session will be presented in August.

As part of this process there has been a review of the documentation required for RCA reporting. This will become standard as of 2006. Details will be sent out to all health services.

Victoria
The Place To Be

Lessons from the Sentinel Event Casebook continued…coordination of care

and was unaware that the chest X-ray was not part of the normal routine.

On checking, it was noted that the patient did not require and was not ordered a chest x-ray. The patient received unnecessary exposure to radiation.

What were the major contributing factors in this case?

- Staff did not follow normal practice of identifying each patient against the radiology request to ensure the correct patient was receiving the correct procedure.
- The radiographers on duty were mostly junior and the unit was busy with two staff on sick leave.
- The patient was unaware and not informed of what to expect in relation to the procedure, so did not question staff.

How did the health service address these issues?

- Reviewed the event, and educated staff on the positive patient identification policy in the unit to ensure the correct patient undergoes the correct procedure.
- All patients to be informed of what to expect when having procedures done, and encouraged to question procedures that are unexpected or have not been discussed with them.
- Staff management improved, with emphasis on appropriate supervision of junior staff.

How does your organisation manage patient identification issues within all departments of your health service?

Many health services now adopt patient identification policy/procedures, which require all staff to check that the correct patient is receiving the correct procedure. An example of this is ensuring that the medical record number on the patient's identification label matches the number on the request form. Where verbal checks are not available, a photograph of the patient will be used on treatment forms

National Inpatient Medication Chart (NIMC)

In 2004 Australia's Health Ministers agreed that in order to reduce harm to patients from medication errors, all public hospitals would be using a common medication chart by June 2006. This means that the same chart will be used wherever a doctor or nurse works and wherever a patient is within a hospital in Australia.

The Victorian Medicines Advisory Committee (VMAC) has been working with State and Federal bodies to develop a standard National Inpatient Medication Chart (NIMC). Go to the website www.health.vic.gov.au/vmac to find out about:

- rationale and background
- current versions of NIMC
- frequently asked questions
- feedback from pilot sites

Infection Control Issues: medication safety in theatres

The Victorian Advisory Committee on Infection Control (VACIC) have reviewed a number of sentinel events. They have requested that the Department of Human Services bring to health services attention the risks and practices of medication use in theatres. Potential concerns for error include:

- Drawing up medications for all patients at the commencement of a theatre list:
  - medication for each patient should be drawn up at the commencement of each case. This reduces the potential for error in administering the wrong medication to the wrong patient.
- Medications which are drawn up should be labelled with:
  - the patient's name
  - the name of the drug
  - date and time drug drawn up.
- Disposal of medication:
  - all medications used in the procedure should be disposed of appropriately at the conclusion of that procedure.
- Handing over medication to another person.
  - where there is a change in anaesthetist during a case, all medications in use should be included in that handover, and follow the college 'Guidelines on the Handover of Responsibility During an Anaesthetic', available at www.anzca.edu.au/publications/profdocs/profstandards/ps10_2004.htm
- The use of medication vials (single use):
  - should only be used for single patient use as prescribed by the Therapeutic Drugs Administration Act.

Quote of the month

"Human beings, who are almost unique in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so."

Douglas Adams

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