Risk Watch

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Lessons from the sentinel event casebook

Management of a Pregnant Woman with an Emergency Presentation

A number of recent events and near misses highlight a need for clarity regarding the emergency support services for obstetric and maternity services in Victoria.

The transfer of a pregnant woman should be considered when the team suspect the existing health service is not equipped to provide safe care of the woman and unborn baby. In general, outcomes for babies who need intensive care in the newborn period improve if the mother can be transported pre-delivery to a tertiary maternity service.

The method and timing of transfer depend on the clinical scenario, the distance and at times the geographic and climatic conditions.

The Perinatal Emergency Referral Service (PERS) was established in November 2005. One of PERS primary functions is to streamline the location of an appropriate bed when a woman develops major difficulties during pregnancy and around the time of birth.

PERS is co-located with Neonatal Emergency Transport Service (NETS) however it is NOT a retrieval or transport service.

Instead, by calling the 24 hour 'PERS & NETS Emergency Hotline-1300 137 650' any clinician dealing with a potential perinatal problem can rapidly access advice from a senior obstetrician and gynaecologist.

Where appropriate, conference calls can be established between the referring clinician, PERS obstetrician, NETS neonatologist, and a clinician at the prospective receiving hospital, to establish a management plan.

Treatment protocols have been developed between PERS and the three Victorian tertiary maternity hospitals (Mercy Hospital for Women, Monash Medical Centre and Royal Women's Hospital) for a number of common perinatal problems,

- Preterm labour
- Preterm premature rupture of membranes
- Ante partum bleeding
- Hypertensive disorders
- Significant postpartum haemorrhage

Although every effort is made to direct women to the nearest hospital with appropriate services, this may not always be possible. In sourcing a bed, consideration is given to the availability of Neonatal Intensive Care Unit (NICU) beds at each of the tertiary maternity units. The negotiation is done in consultation with the NETS neonatologist, and if necessary, the individual NICU Directors.

Transport of any patient is potentially dangerous, and the risks of transport / transfer must always be taken into account when clinical decisions are being made. An aircraft is clearly not an appropriate place for a birth to occur.

Responsibility for arranging ambulance transport sits with the referring clinician through either the Metropolitan Ambulance Service (MAS), or in the regional and rural sector Rural Ambulance Victoria (RAV).

It is important the referring clinician be clear in their communication on the nature of the emergency and level of risk.

The emergency transport service need to ensure the lines of communication remain open with the clinician, particularly where potential delays to transfer are experienced. The rationale for any changes to transport arrangements should always be made clear to the referring clinician.

Where clinician escort is required to facilitate safe transport, staff will need to be provided by the referring hospital. PERS do not dispatch specialist staff to health services.

In some cases, after consultation the woman may not require transfer, and an alternative plan of management is adopted. In other cases, if it appears likely that despite efforts to delay labour, delivery is imminent or may occur in transit, the NETS team may be sent to retrieve the newborn.

In this scenario the birth would proceed in the referring hospital.

Not all women transferred to a tertiary maternity service will deliver on that admission. Once their immediate problem resolves and/or they reach a safer gestation period, the woman would ordinarily be transferred back to their original referring clinician.

Additional information on PERS and can be sourced via www.pers.org.au/

Information relating to NETS can be sourced via www.nets.org.au/

When is a Complication an Incident?

The Department of Human Services (the Department) Clinical Risk Management staff often receive calls from clinicians asking if a significant patient complication is considered an adverse event / incident.

An adverse event resulting in serious morbidity or mortality warrants review by the health service. The review assists to understand the circumstances under which the event transpired and any contributing factors. The lessons learned from such reviews lead to system changes that minimise the occurrence of similar events in the future.

The scenario below was published in a 2006 Queensland Health Patient Safety Centre newsletter "Patient Safety Matters" and has been included here with their consent. It is an excellent example of a complication that leads onto an adverse event / incident.

Case Scenario

A woman is admitted at term, with ruptured membranes and in early labour. There are no signs of infection and the patient is happy to progress to a natural delivery.

Victoria
The Place To Be

Lessons from the Sentinel Event Casebook continued…

She doesn't go into established labour and after 24 hours and discussion with the healthcare team opts for prostoglandins to try and speed things up.

Is this an intervention or an adverse event?

If so from whose perspective; the patient, the doctor or the nurses?

The Patient Safety Centre Response:

This is a therapeutic intervention.

The prostaglandins bring the patient into labour; she progresses well and has a natural delivery but sustains a 3rd degree tear during second stage (labour).

Is this an adverse event? If so from whose perspective; the patient, the doctor or the nurses?

Patient Safety Centre Response:

An adverse event is defined as "an incident in which unintended or unnecessary harm resulted to a person". The 3rd degree tear is an adverse event and should be reported.

If so, from whose perspective?

An adverse event should always be viewed from the patient perspective. It is about unintended harm rather than a notion of who is responsible or liable.

The patient has a perineal repair and at day 3 is found to have an infected perineal wound.

Is this an adverse event? If so from whose perspective; the patient, the doctor or the nurses?

Patient Safety Centre Response:

Once again when viewed from the patient's perspective, this is an adverse event.

The woman is treated successfully with antibiotics and is discharged. The wound doesn't heal well and is still painful and oozing at the postnatal check. The patient is eventually diagnosed with a recto-vaginal fistula.

Is this an adverse event? If so from whose perspective; the patient, the doctor or the nurses?

Patient Safety Centre Response:

Once again from the patient's perspective this is an adverse event. When you ask the question "from whose perspective", you refer to a notion of causality and liability rather than outcome. Individual liability or indeed preventability is a separate issue to patient harm.

Can a recognised complication still be an adverse event or incident? How do we manage the information and investigation in this sort of circumstance?

The initial adverse event of the 3rd degree tear leads to the subsequent adverse events.

An adverse event should be reported

1. To ensure that the appropriate immediate treatment is provided and documented.
2. To facilitate appropriate patient disclosure and expression of regret.
3. To ensure that the appropriate level of analysis occurs aimed at preventing similar events in the future.

A recognised complication certainly can be an adverse event. As discussed above, we need to separate the identification and appropriate management of patient harm (whether preventable or not) from notions of causality or liability.

How would your health service view this or a similar scenario? Would you report this as an adverse event / incident?

Thank you to our Queensland Health colleagues for their permission to use this article in Riskwatch.

National Sentinel Event Report 2004–05

The Australian Institute of Health and Welfare (AIHW) in conjunction with the Australian Commission on Safety and Quality in Health Care released the inaugural national Sentinel Event Report 2004 – 2005 in July 2007.

An electronic copy of the report can be accessed via www.aihw.gov.au/publications/index.cfm/title/10353

Credentialling and defining scope of clinical practice

It is essential that all medical practitioners who have independent responsibility for patient care within health services across Victoria are appropriately credentialed. That they have their scope of clinical practice defined in accordance with their level of skill, and experience, as well as the capability of the health service.

The former Australian Council for Safety and Quality in Health Care developed a national standard to guide this process: *Standard for credentialing and defining the scope of clinical practice*, July 2004 (the 'National Standard').

Building on the National Standard, the Department has formulated a consistent approach for credentialling and defining scope of clinical practice to be implemented in all Victorian publicly funded health services. The policy applies to all senior medical staff appointed to a public health service, public hospital or multi purpose service.

An outline of the Victorian policy handbook can be sourced via www.health.vic.gov.au/credentialling/index.htm or by contacting Jeanette Bell on 9096 9030, or jeannette.bell@dhs.vic.gov.au

Incident Information System (IIS)

The IIS Project Advisory Group and Project Board recently endorsed the Incident Information System (IIS) data dictionary.

In preparation for formal system piloting during 2008, it has been deemed important to further refine two key components of the IIS data dictionary. A small representative group of acute and community health services will test the IIS incident classification model and severity rating methodology during September, October and November 2007.

Further information can be obtained from the IIS project website, www.health.vic.gov.au/clinrisk/iis or by contacting Danielle Whitman the IIS project manager on 9096 8964 or danielle.whitman@dhs.vic.gov.au

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