

Risk Watch

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What do we do with Coronial Recommendations?

When the Coroner holds an inquest, the case is summarised in a 'Record of investigation into Death'. The Coroner may have identified systems failures in the case and may make recommendations. The aim of recommendations is to reduce the risk of an adverse event recurring. This makes the work of the State Coroners Office a QI activity!

The Coroner may refer recommendations onto the Department for distribution to relevant health services, hospitals, GP Divisions and other health-related organisations. The Department will ask the health service or hospital involved in the case to write about the systems issues in the case, and to say how these have been addressed. This is not a punitive measure. We can all learn from the adverse event by reading the case report and its lessons.

Under the clinical governance responsibilities, each CEO should ensure that their Board Quality Committee reviews and considers all coronial recommendations. The committee must ensure that hospital management has addressed any relevant findings. Each year, the Board Quality Committee must produce a 'Health Service Quality of Care Report'. Reporting on actions relating to coronial recommendations is a compulsory requirement in this report.

The National Coronial Information System (NCIS) now pools all coronial investigations and recommendations across Australia. This allows rapid identification of similar adverse events or similar factors in accidents. It provides the potential to identify broad (or specific) systemic problems in a timely way.

ERROR PRODUCING CONDITIONS AND THEIR RISK FACTORS

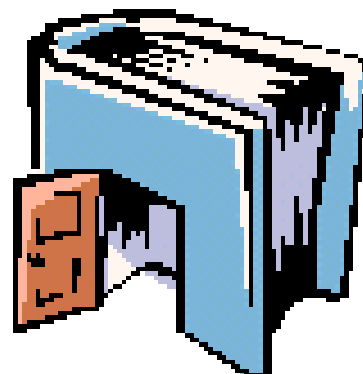
Possible reasons why that error occurred

- **Unfamiliarity with the task (x17)**
- **Time shortage (x11)**
- **Poor human / system interface (x8)**
- **Designer User mismatch (x8)**
- **Irreversibility of errors (x8)**
- **Information overload (x6)**
- **Misperception of risk (x4)**
- **Poor feedback from system (x4)**
- **Inexperience – not lack of training (x3)**
- **Poor instructions or procedures (x3)**
- **Inadequate checking (x3)**
- **Educational mismatch of person with task (x2)**
- **Disturbed sleep pattern (x1.6)**
- **Hostile environment (x1.2)**
- **Monotony and boredom (x1.1)**

(James Reason "Understanding adverse events: the human factor")

A frequent comment in Root Cause Analyses and Coronial Investigations is that staff members were unaware of specific policies. Could this be a root cause?

**"The covers of this book are too far apart."
Ambrose Bierce (1842-1914)**



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Patient Safety is
Our First Priority



LESSONS FROM THE SENTINEL EVENT CASEBOOKS

A patient is admitted to a public hospital for invasive investigations. The consent form is signed. A complex, highly technical procedure is performed by a Registrar, under supervision of a Consultant. An error is made and the patient dies. The patient and the relatives were not told that the Registrar would be performing the procedure. Hospital management suggest that when a patient comes into a teaching hospital, he or she gives implicit consent to being involved in medical teaching and training.

Some medical practitioners, such as surgeons and obstetricians, must be technically competent in very complex procedures. An apprenticeship training system such as medicine depends upon immersion in practice. There will always be tensions between service and educational needs in a health care organisation, but this is usually situational and dependent upon the teacher and the learner.

The notion that the patient has given implied consent by accepting admission into a teaching hospital is pervasive but quite **erroneous**. The patient has a legal and ethical right to direct what happens to his or her body. When obtaining consent, the following issues must be discussed:

- The nature of the procedure.
- Any reasonable alternatives to the proposed intervention.
- The relative risks, benefits and uncertainties of each procedure.

If the patient has been admitted as a public patient, s/he cannot choose the Consultant under whose care s/he is admitted. However the patient must be informed who will be performing the procedure and that the proceduralist is a trainee. S/he has the right to refuse to have a trainee perform the surgery, procedure or investigation. Safety should not be compromised for the sake of training. There should be no perception that there are two standards of care: one for the private patient and another for the public patient. Teaching and safety can be compatible.

READ ANY GOOD ARTICLES LATELY?

We recommend:

Clark G. Organizational culture and safety: an interdependent relationship. Australian Health Review 2002; 25(6); 181-189

Risk Watch values feedback. If you have any ideas, stories, lessons or comments, please send them to:

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