



Facts from the Sentinel Event Casebook and the Coroner's Casebook

Do you read the Manufacturer's instructions?

February's Coronial Communique's analysis of case number 2116/00, in which a patient died following a guide-wire exchange of an intravascular dialysis catheter, highlighted the need for organisations to ensure that the following occurs:

- "Hospital procedures ensure that following insertion, manipulation or exchange of a central venous catheter, a CXR or fluoroscopy are routinely performed and reviewed in order to confirm satisfactory tip position.
- Procedures relating to the checking of x-rays by clinicians exist to ensure that system errors...are avoided".

(Coronial Communique Vol 1, Issue 2, P4)

The Coroner's Report also highlighted that the manufacturer's instructions had clearly indicated the need to confirm the position of the catheter tip with a chest x-ray. Organisations should consider acknowledging the manufacturer's recommendations in the development of procedures/protocols for clinicians.

The system issue relating to checking the x-ray of this patient was complicated due to the patient's subsequent transfer to another ward prior to the x-ray check occurring. Again, a simple process of ensuring that the x-ray results are documented and handed over to the staff in the new setting can result in the management plan of a patient changing to support a more appropriate course of care as per the results of the x-ray.

Refer to www.health.vic.gov.au/cls for further information about this case.

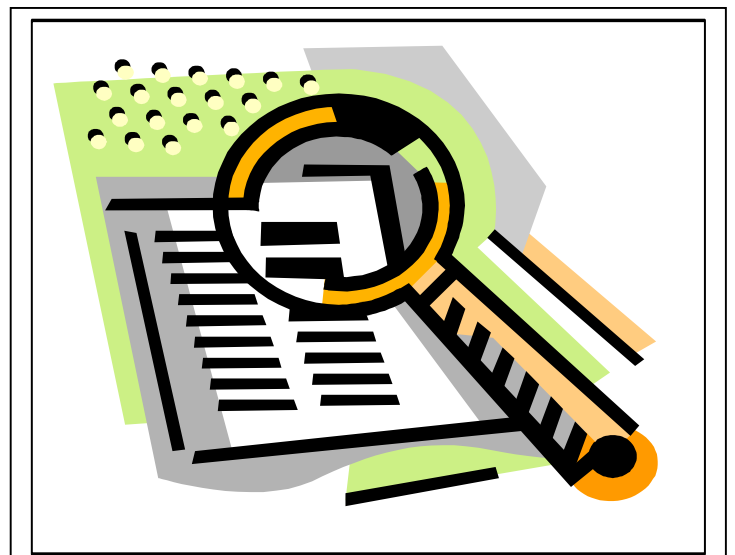
How do you know that the right patient is not receiving the wrong surgery?

The Victorian Surgical Consultative Council's advice was sought to address system issues involved with Sentinel Events relating to surgery on wrong patient/body part.

The Council has advised that the 'Correct Side and Correct Site Surgery Guidelines' document recently released by the Royal College of Surgeons in collaboration with the Council, is an appropriate set of guidelines for all organisations to read, review and instigate as appropriate.

The 'Guidelines' is a simple one-page document identifying 10 easy steps to ensure that the right patient receives the right surgery on the right body part.

To view this document please go to:
http://www.health.vic.gov.au/vscc/articles/correct_side.pdf



Did You Know That...

Did you know that the Department, through the Sentinel Events Program, calls on the expertise of the following Councils to review specific Root Cause Analyses relating to their specialty. These include the following:

- Consultative Council on Anaesthesia Mortality and Morbidity;
- Surgical Consultative Council;
- Consultative Council on Obstetric and Paediatric Mortality and Morbidity;
- Victorian Quality Council;
- Victorian Advisory Committee on Infection Control;
- Australian Red Cross Blood Service Victoria;
- Principal Nurse Advisor, Nurse Policy Branch;
- State Trauma Committee;
- Chief Psychiatrist.

The Councils provide written advice on each submitted Sentinel Event. The Department then notifies the reporting organisation of recommendations and if appropriate, the recommendations are made available for Health Services across the state. The Sentinel Events Casebook in this month's edition is an example of the collaboration between the Health Service, the Department and the Surgical Consultative Council.

Quote of the Month

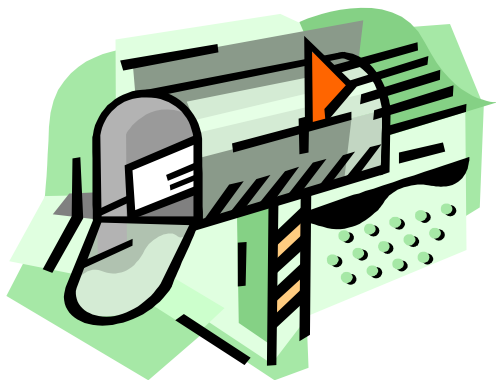
The feature that distinguishes the best health organisations is their culture."

L. Donaldson, BMJ 1998.

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Risk Watch is not for circulation to the community. Please ensure that it is not in waiting rooms, on websites or public noticeboards. It is to support safe clinical practice and is published for those working in the health field.

What is LAOS?

The Limited Adverse Occurrence Screening (LAOS) Program is an essential component of Victoria's small rural health services' Clinical Risk Management (CRM) strategy. This program is auspiced by five lead Divisions of General Practice in Victoria, and supports a peer review of rural GPs in their role as VMOs in health services.

The LAOS Program does not negate the Sentinel Event Program or incident reporting programs, which health services currently utilise. Its aim is to support a review of specific medical records using the Woolfe Criteria. GPs then review specific admissions and provide recommendations on changes in practice that can prevent adverse events or near misses. The recommendations are sent to Health Services for incorporation into their CRM programs. Future editions will include lessons learnt from the rural field.

An update on Paediatric Paracetamol

Risk Watch recommends that clinicians check the Paediatric Pharmacopoeia for accurate dosages with children who are being cared for in an acute setting, as their medical condition may influence the dosage required. Also of note is the Therapeutic Goods Administration's leaflet for practitioners in the use of paracetamol. The website is as follows:

<http://www.tga.health.gov.au/docs/html/paracetpr.htm>

Why reinvent the Wheel?

Do you need help developing a policy for your health service and haven't been able to track down a copy of a similar policy? Please contact Risk Watch and we will ask for help from other health services?

A request for a policy on 'Risk Management' has been received. If you have a policy that you would like to share, please let Risk Watch know and we will send it on.