

# Risk Watch

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## Lessons from the sentinel event casebook

### Potential for error – equipment issues

A patient was admitted to hospital with a chronic medical condition requiring medication to be given through an intravenous (IV) line, and their oral medication through a feeding tube inserted directly into the stomach known as a PEG tube, due to swallowing difficulties.

Two nurses checked and prepared this patient's morning medication. The oral medication (potassium chloride (KCl)) was drawn up in a syringe to be given via the PEG tube. The syringes containing both the IV drug and oral drug were put into a kidney dish to take to the bedside. The second nurse was called away to assist with another patient's care.

The nurse responsible for the drug administration proceeded to give the oral KCl through the IV line instead of the feeding tube. The patient immediately experienced difficulties, needing resuscitation. This resulted in the patient spending five days in ICU.

### What were the major contributing factors in this case?

Equipment could be used for more than one purpose – the syringes in use were able to fit both the IV lines and the PEG tube.

### How did the health service address these issues?

- Purchased different syringes for oral/enteral and IV access – syringes not compatible for any other intended use.
- Developed policy on transporting medications – separate oral/other medications and IV medications
- Labels required on all syringes identifying drug and route.

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

Is there an attempt to standardise equipment within your hospital/health service?

## Update on Steal Syndrome

### Regional anaesthesia – early consultation for neurological complications

Further to our recent articles on a sentinel event of steal syndrome in arterio-venous fistula formation ([www.health.vic.gov.au/clinrisk/march2004riskwatch.pdf](http://www.health.vic.gov.au/clinrisk/march2004riskwatch.pdf) and [www.health.vic.gov.au/clinrisk/riskwatchaug2004.pdf](http://www.health.vic.gov.au/clinrisk/riskwatchaug2004.pdf)), we note the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) have endorsed an article on the management of neurological complications of regional anaesthesia.

Key issues are:

- interdisciplinary consultation prior to major regional anaesthesia for patients with major co-morbidities that may increase the risk of complications
- early detection of neurological compromise through provision of ongoing education of nursing and medical staff and protocols for observation and management of patients post regional anaesthesia
- urgent communication with the anaesthetist/anaesthetic service at the onset of any signs or symptoms of neurological compromise to ensure co-ordination of the peri-operative care and early assessment, investigation and treatment of complications.
- an obligation of the anaesthetist concerned to ensure ready availability or to nominate an alternative consultant

The full article may be viewed on VCCAMM's website [www.health.vic.gov.au/vccamm/articles/neuro.pdf](http://www.health.vic.gov.au/vccamm/articles/neuro.pdf)

### Policy prowl patch

Policy required on Familial Cancer Risk Management within General Practice –email to [family.cancer@cancervic.org.au](mailto:family.cancer@cancervic.org.au)

## Lessons from the Sentinel Event Casebook continued...

### Focus on contributing factors

Each root cause analysis identifies the contributing systems factors that impacted on the events' occurrence. For more information see the Sentinel Event Program Annual Report 2003-04 [www.health.vic.gov.au/clinrisk/sentin.htm#anrep0304](http://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

A patient on long-term warfarin therapy was admitted for emergency heart surgery and had her medications changed whilst in hospital. The patient presented to an emergency department bleeding internally five days after discharge.

The main issue identified was related to documented plan of care on discharge for ongoing warfarin management detailing:

- target dose, expected range and next test date
- recent results including doses withheld and why
- changes to the patient clinical condition and list of new medications including any potential side effects to warfarin management.

### Action plan

1. Formal documented process for management of warfarin at discharge, and copy of plan given to patient outlining clear plan of care and expectations.

Does your organisation have a standard documented process for management of patients on warfarin with alerts to ensure care is appropriate, planned and communicated to all involved in their care including the patient?

### Coordination of care

A transplant patient developed an infection following their surgery from bacteria resistant to the ordered antibiotics (AB's). An assumption had been made that the AB's ordered would cure the infection before surgery, and had been ordered without checking results of the specimen taken. The patient had become resistant to the prescribed AB's. This resulted in extensive post-operative treatment and a prolonged hospital stay.

### Action plan

1. Routine pre-operative checklist to ensure all investigative results reviewed by medical team prior to invasive treatment.
2. Checklist to ensure high-risk patients are identified and referred to parent unit prior to planned surgical treatment.

Also see VQC site 'The impact of communication of test results on appropriate patient care: case examples and literature overview' at

[www.health.vic.gov.au/qualitycouncil/plans/appcare\\_5e.htm](http://www.health.vic.gov.au/qualitycouncil/plans/appcare_5e.htm)

Does your organisation have a policy/procedure to ensure all investigations are signed and reviewed prior to medical record filing?

Do you identify high-risk groups and alert primary care unit in decision making when admitted through other paths?

### Human resources

A patient received an overdose of insulin resulting in the need for immediate medical intervention and ongoing monitoring.

A contributing factor in this event was the unfamiliar setting for staff who were covering sick leave, who were themselves unwell, and not familiar with diabetic patient management. There was a culture in the organisation for staff to present for duty when unwell.

The patient's care was complicated by an unclear guideline for the emergency management of diabetics.

### Action plan

1. Re-enforcement of sick leave policy to staff and awareness of decreased performance when affected by illness.
2. Ensure staff skill mix meets the clinical care needs of the unit.
3. Medication management and competency tool be developed and implemented for all nursing staff.
4. Develop standard diabetic management guideline to ensure all medical and nursing are aware of plan of care, roles and responsibilities in managing this patient group, especially in emergencies.

Does your organisation have a policy/procedure to ensure medication competency of staff and standardised guideline on management of diabetes including emergency management outlining roles and responsibilities?

## Quote of the month

"A well-lead, well-managed, healthcare organisation will seek to minimise such incidents by preventing their occurrence and acting swiftly to limit their adverse consequences"

*Sir Liam Donaldson,  
1999, Medical Mishaps:  
Pieces of the Puzzle*

Risk Watch is produced by  
The Office of Chief Clinical Advisor (050404)  
Department of Human Services,  
16/555 Collins Street Melbourne  
Telephone 03 9616 7916 Fax 03 9616 8010  
email: [Riskwatch@dhs.vic.gov.au](mailto:Riskwatch@dhs.vic.gov.au)  
Clinical Risk Management  
website: [www.health.vic.gov.au/clinrisk/](http://www.health.vic.gov.au/clinrisk/)