

Risk Watch

February 2006 – volume 4, issue 2

Lessons from the sentinel event casebook

Potential for error – coordination of care

A patient presented to emergency in the early hours of the morning with a history of bleeding. The case was discussed with the registrar over the phone and managed by the resident on duty in emergency.

On initial presentation the patient was stable and managed conservatively, however, their condition deteriorated and it was decided to give both red blood cells (RBC), and fresh frozen plasma (FFP).

All investigations were completed and the patient's blood type was checked and cross matched in pathology. The blood products were delivered to the emergency department and transfusion commenced.

It was noted that the FFP was of a different blood group to the RBC, not all blood groups are compatible. The staff called the pathology service and were assured that this was not a problem, and the product was appropriate for the patient. The staff continued with the transfusion, and all routine transfusion observations were unremarkable.

Later in the morning the pathology service contacted the emergency department to inform them the product was in fact incorrect.

The patient, although showing no adverse symptoms was required to spend 24 hours in intensive care for observation and monitoring.

Despite all appropriate checks and follow up to clarify the use of this product, the patient still received the wrong product and was put at potential risk.

What were the major contributing factors in this case?

- Facilities management:
 - The pathology department provided and verified the wrong blood product.

- Human Resources:
 - The resident did not contact the registrar when the patient's condition deteriorated.
 - Nursing staff did all appropriate checks, but received incorrect information from the pathology service.
- Procedures/guidelines were not followed:
 - The unit guideline for medical review was unclear, though did state the medical registrar should review patients in emergency if their condition deteriorates.

How did the health service address these issues?

- Developed admission guidelines, which outline if patients condition deviates from agreed management plan, registrar review is mandatory. This is incorporated into the resident's handbook and staff orientation.
- Developed a blood compatibility/transfusion chart to be included in blood transfusion therapy guideline.
- Engage private pathology service to ensure they review internal systems in relation to transfusion practices.

Cross matching (laboratory compatibility testing) is not required for FFP. While FFP, which is ABO identical to the patient's group, is preferred, ABO compatible plasma (i.e. compatible with the recipient's red cells) may be used if ABO identical FFP is not available.

Group AB FFP is compatible with all blood groups and may be used in an emergency where the patient's blood group is not known, or where ABO identical FFP is not available.

For further information go to the Australian Red Cross Transfusion website www.transfusion.com.au

Equipment

The introduction of new equipment, including new technology should be managed to ensure minimal risk exposure.

Issues involving equipment as contributing factors in sentinel events result from either multiple types of equipment being available, or inadequate training and orientation to new equipment.

Lessons from the Sentinel Event Casebook continued...assessment

In order to minimise risk, standardising equipment used and ensuring staff familiarity of equipment across the organisation is a big step. Many health services now limit the types of intravenous and syringe pumps in use. This reduces the risk of error due to variation in practice and equipment.

When introducing new technology and information systems, it is always essential to ensure they include a risk management plan, and are tested to failure; for example, what happens if the system fails and how does it impact on other systems in the health service?

Potential for error – guidelines and protocol

A patient was prescribed penicillin, despite an allergy alert being well noted throughout the medical history, and alerts placed on medication chart, that there was an allergy to penicillin. There was no allergy alert bracelet and name band did not alert the staff to any risks.

The nurse discussed medications with the patient prior to giving, but did not ask if the patient was allergic to anything. The patient was not aware the medication prescribed – amoxicillin – was penicillin, so did not question any further or raise concerns.

Shortly after taking the medication the patient collapsed and required transfer to intensive care in anaphylaxis (allergic reaction) and required further medical treatment and observations.

What were the major contributing factors in this case?

It was well documented the patient had an allergy to penicillin yet it was still prescribed and given. Both the medical officer prescribing the medication, and the nurse caring for them on that day were unfamiliar with the patient.

There was no ward pharmacy staff that may have detected this error.

There was a clear failure to follow standard medication procedures in checking for allergies when prescribing medications.

How did the health service address these issues?

- Medical and nursing staff to clearly ask patients about allergies prior to prescribing and or dispensing medications.
- Patient name bands to have a coloured label to alert staff to allergy present.
- Educate staff to awareness of allergy status in all patients.
- Include ward pharmacy cover to provide medication advice and to check patient medication chart.
- Review medication charts in use to standardise documentation of charts, and reduce variation in practice and where allergy alerts posted.

How does your organisation manage patients with allergies? What does your organisation do to prevent this event or similar occurring?

Recent Coroners Cases

Effective communication with family members

Recent coroner findings have highlighted the importance of effective communication with family members and involving interested family members when communicating health information to the patient.

Whilst good communication with a patient is important for the provision of health care, keeping family members “in the loop” at each stage of healthcare allows for better:

- Collection of additional information on symptoms and signs, which the patient may not be able to provide;
- Consideration of differential diagnoses;
- Provision of comfort to the patient and family, by being informed;
- Understanding each step in the patient’s healthcare; and
- Decrease in confusion and anger of family members after patient death.

Administration of Total Parental Nutrition (TPN)

TPN is used to ‘feed’ patients unable to take oral diet, or to support and provide further nutrition in cases where the patient has poor nutritional status. TPN is given via a special intravenous line that is inserted into a larger blood vessel, often close to the heart.

In one case, the coroner found a causal link between the death of the deceased and a failure to adequately monitor TPN administration. In this case, the patient had dysphagia (inability to swallow). An infection of the intravenous line led to multiple organ failure. The coroner noted that whilst giving consideration to the individual circumstances, in general enteral nutrition (being fed directly into the stomach via a tube) should be favoured over intravenous nutrition in the presence of a functioning stomach. Further, when TPN is chosen, a multidisciplinary staff team experienced in its management should undertake supervision of TPN administration.

Sites of interest

Complete reports of coroner findings may be obtained from the State Coroner’s Office of Victoria (www.coronerscourt.vic.gov.au).

Quote of the month

“It is a capital mistake to theorise before you have all the evidence. It biases the judgment.”

Sir Arthur Conan Doyle (1859-1930), British writer, physician, created Sherlock Holmes”

Risk Watch is produced by
The Quality and Safety Branch (RCC_060304)
Department of Human Services
16/555 Collins Street Melbourne
Telephone 03 9616 7916 Fax 03 9616 8010
email: riskwatch@dhs.vic.gov.au
Clinical Risk Management
website: www.health.vic.gov.au/clinrisk