

Risk Watch

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Lessons from the sentinel event casebook

Potential for error – coordination of care

A patient was transferred from a small rural emergency facility direct to a radiology service for further investigation.

The ambulance transported the patient to the radiology service, which was attached to a larger health service and was located next to the hospitals' emergency department.

Following the X-ray, the patient was wheeled into the emergency department next door, whilst waiting for the results to be reviewed.

The patient was not an admitted patient of this emergency department. The radiology unit had used the emergency department as an observation and waiting area due to space and prior staff issues.

The emergency nurse was not given a clear hand over on the patient's condition. It was assumed the patient would be returning to the referring health service for follow up and treatment.

The patient's condition deteriorated whilst in the emergency department and needed urgent treatment.

What were the major contributing factors in this case?

- Facilities management:
 - The emergency department was used as a holding/waiting area for the radiology department.
- Human resources:
 - Radiology service did not have adequate staffing to supervise patients managed within that service.
- Procedures/guidelines were not followed:
 - A patient was placed in emergency without being assessed and admitted to the service.
 - A comprehensive handover and history was not provided to the emergency department staff.

How did the health service address these issues?

- Developed admission guidelines for emergency department to ensure all patients being admitted or transferred into the emergency department are to be assessed and admitted as patients of that department.
- Clinical handovers are to be detailed and completed on all transfers.
- Radiology department staffing to be evaluated to ensure appropriate cover is provided for the service.

How does your organisation address the issue of triage and emergency department practices within your health service?

Clinical Guidelines

The absence or lack of knowledge about procedures and/or guidelines, accounted for 31% of contributing factors in the 122 sentinel events analysed for 2004-05.

One way to reduce overall risk is to standardise processes and systems. The use of clinical guidelines/procedures is a way to ensure there is a standard approach to managing clinical conditions.

Many colleges and councils have working groups to research and develop relevant clinical guidelines. These guidelines are based on best evidence practice, and are made freely available to their members, and often the wider industry upon request.

Large specialist health services are also leaders in developing evidence based procedures and guidelines related to their specialties.

If your organisation is in the process of developing guidelines, the relevant colleges and councils, and specialist health services should be the first point of contact to ensure you are not "reinventing the wheel".

One size does not fit all, however the core intent and practice should be consistent, with variation to fit the local application.

Sentinel Event Reporting 2005-06

St John of God Health Care is the first group of private hospitals to join the Victorian sentinel event program.

Lessons from the Sentinel Event Casebook continued...assessment

This health care group will commence reporting into the program as of January 2006.

RCA Module 3 Education 2006

Further education on Module 3 root cause analysis will be undertaken in 2006, (dates and venues to be confirmed). To enable future planning, health services should provide details of staff wishing to attend to Module 3 education sessions to:

Deane.Wilks@dhs.vic.gov.au.

Limited Adverse Occurrence Screening

The Department of Human Services introduced the Limited Adverse Occurrence Screening (LAOS) program in 2001 for small Victoria's small rural hospitals following the development of Victoria's Clinical Risk Management (CRM) Strategy. The LAOS program has endeavoured to improve patient safety in small rural hospitals by identifying preventable adverse events in acute patient episodes of care, and the subsequent underlying systemic issues, thereby influencing changes in clinical practice and organisational systems as required. Four years on from the implementation of the LAOS program the department has undertaken an evaluation of the program to determine its acceptance and progress by stakeholders.

The report will be widely available in February.

Sites of interest

2004-05 Sentinel Event Annual Report

The Sentinel Event Program Annual Report 2004-05 has been printed and will be distributed to all health services.

This report was released publicly and to the media in early November, and is available on line at: www.health.vic.gov.au/clinrisk/annrep0405.pdf

Health Services Commission

The Office of the Health Services Commissioner has just released its 2005 Annual Report.

This report outlines common themes and issues raised through complaints management and some insight into how they are managed.

For the full report go to: www.health.vic.gov.au/hsc

Victorian Public Healthcare Awards

The aim of these awards is to celebrate and acknowledge the quality, innovation and excellence in public healthcare.

The inaugural awards were held in November, with over 203 entries received.

A showcase of the winning programs is available at: www.health.vic.gov.au/healthcareawards

Congratulations to all the health services for their commitment to continuing the safety and quality of health care provided to all Victorians.

Planning is already underway for the 2006 awards. Information will be posted on the website above as details are finalised.

Conference and Workshops

The 4th Australasian Conference for Safety and Quality in Health Care 'Raising the Bar for Quality' will be held in Melbourne, Australia on 21-23 August 2006.

The Australasian Association for Quality in Health Care (AAQHC) have partnered with the Australian Council on Healthcare Standards (ACHS) to ensure the conference will be presenting a program of international and local speakers, and provide the opportunity to participate in skill and knowledge improvement workshops.

Adjunct Professor Professor Lucian Leape will attend this forum as the international keynote speaker. He has been an outspoken advocate of the non-punitive systems approach to the prevention of medical errors and has talked and written widely about the need to make patient safety a national priority.

Check out further details at:

www.sapmea.asn.au/conventions/sqhc2006/index.html

Quote of the month

"Our lives begin to end the day we become silent about things that matter."

Martin Luther King, Jr.

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