

Risk Watch

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Lessons from the sentinel event casebook

Potential for error – procedures/guidelines

Two patients on the same ward were ordered blood transfusions overnight. The blood was delivered to the health service by courier from another site and taken to the ward by the after hours coordinator.

The coordinator only had knowledge of one transfusion order that had been handed over and presumed this was for that patient. It was a busy night with many postoperative patients requiring intensive nursing care.

The patient receiving the transfusion had only just been admitted to the unit directly from theatre, so staff were unfamiliar with the patient.

A nurse was called from another area to assist in the set up and checking of the transfusion as per protocol.

During set up and checking of the blood the patient became agitated and attempted to get out of bed. Distressed, and wanting to use the bathroom, a pan was given to the patient. The second nurse was called back to their area to attend to their patients, and the nurse, after cleaning and settling the patient continued to connect the blood and commenced the transfusion. In the course of disruption and workload both nurses had forgotten that the patient checking procedure had not been completed.

During the next hour the patient became restless and distressed with an increasing temperature. On checking the unit of blood the nurse discovered the blood was for another patient and the transfusion was ceased. The patient was medically reviewed and closely monitored overnight.

Root Cause Analysis (RCA) Education Program - Update

Education in Module 3 continues and the last session will be presented in August.

As part of this process there has been a review of the documentation required for RCA reporting which will become standard as of 2006, details will be sent out to all health services.

What were the major contributing factors in this case?

The investigation found that there were a number of contributing factors that contributed to this event including;

- Communication related to patient details on unit of blood – not handed over using patient label and unique medical record number.
- Staff distraction due to a busy nightshift and high workload of patient care.
- Failure to follow correct identification protocol – where 2 nurses check all details against unit of blood and patient identification label to ensure they match and that the correct patient receives the correct unit of blood.

How did the health service address these issues?

- That laboratory staff communicate directly with the off site unit receiving the blood product of its delivery, and who it is being delivered for.
- When requesting blood or blood products only use unique patient identifiers, such as patient name, date of birth and unit record (UR) number.
- Education program to all staff to ensure correct protocol in management of blood and blood products, right patient receives right transfusion. This includes 2 staff checking all blood and blood products when commencing transfusions, using unique patient identifiers, such as patient name, date of birth and unit record (UR) number, against the unit of blood/blood products.

How does your organisation manage transfusion of blood products?

The Department of Human Services' statewide, Better Safer Transfusion (BeST) Program seeks to support Victorian hospital's efforts to improve transfusion practice (and their patient outcomes) by focussing on the appropriateness and safety of transfusion. Check out their site at www.health.vic.gov.au/best/index.htm

The Australian Red Cross Blood Service has developed a web based resource for both consumers and health professionals, check out their site at www.transfusion.com.au

Lessons from the Sentinel Event Casebook continued...coordination of care

A patient was admitted for surgery with documented allergies to several medicines.

During surgery the patient experienced a hypotensive episode (low blood pressure) and airway problems whilst being given intravenous (IV) medication (not previously noted as being allergic to). It was not certain that this medicine was the only contributing factor to this episode.

The patient responded well to treatment and the potential allergy alert to this medicine was noted on their medication chart.

A few days later another medical specialist was asked to review the patient in regard to another medical matter, and ordered this medicine on the intravenous medication chart (a separate chart) as treatment. The nurse contacted the surgical team to confirm this order. The team were in surgery at the time of the call, and the intern took the call in theatre, there was no discussion of the patient's allergy status, and the order was confirmed.

On being given the IV medication the patient experienced sudden collapse and required resuscitation. They were transferred to the intensive care unit for stabilisation and observation over 24hrs and recovered well.

What were the major contributing factors in this case?

- No recording of allergy alert on IV medication chart – no space for allergy alert on this chart.
- The main medication chart was not referred to in this process, which would have alerted the staff to the allergy.
- Separate charting of medicines, more than one place to document and order medication.
- Communication of medication over the phone without the allergy background information being included in this discussion.

- The patient was not wearing an allergy bracelet (a red hospital ID band), which alerts staff to patient allergy status.

How did the health service address these issues?

- Reviewed IV medication chart to include space for recording drug allergies.
- Reinforce use of clinical history and current medication (including allergies) in all aspects of medication prescribing, dispensing and administration processes. Looking at electronic prescribing systems, which restrict functions such as prescribing medication when a known allergy, and reduce potential for error.
- To include patients medication history (and allergy status) is provided for all phone orders.
- Reinforce policy of allergy alert bracelets on all patients with known allergies.
- Review number of medication charts available, aim for one chart, to reduce potential for error.

How does your organisation manage allergy alerts within your health service?

Does your health service have more than one medication chart in use where medication can be ordered?

The Victorian Medicines Advisory Committee (VMAC)

VMAC replaces the Victorian Drug Usage Advisory Committee (VDUAC).

VMAC will play an important role in ensuring the safe, appropriate and cost-effective use of medications in Victorian hospitals and the wider community. It does this by connecting people for better solutions. Positioned at the hub of an extensive network, VMAC will identify contemporary problems in therapeutics, facilitate independent and expert evaluation of these problems

and ensure appropriate and rapid dissemination of information to those who need it.

The VMAC also has links with interstate and nationally based groups involved in Quality Use of Medicines (QUM).

Within the Department of Human Services VMAC is ideally located within the Quality and Safety Branch and liaises directly with the Victorian Quality Council and the Clinical Governance Unit on all issues surrounding the Quality Use of Medicines.

Check out the website www.health.vic.gov.au/vmac

High Risk Medication Alert - Vincristine

The Australian Council for Safety and Quality in Health Care are in the process of developing a high-risk alert for Vincristine. The Society of Hospital Pharmacists of Australia is preparing the alert, and key stakeholders and interested parties are being contacted and sought to assist in the development.

For more information please contact Naomi Burgess, Project Pharmacist at burgessn@bigpond.net.au

Quote of the month

“The greatest revolution of our generation is the discovery that human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives.”

William James

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