Risk Watch

June 2005 – volume 3, issue 4

Lessons from the Sentinel Event Casebook

Potential for error – coordination of care

A patient presented to emergency with a complex medical history, involving a number of different clinical units, and current symptoms of sepsis (widespread infection). On presentation they also reported ongoing abdominal pain and occasional blood when passing faeces. On rectal examination there was no evidence of melaena (blood in the faeces), and routine investigations were taken including haemoglobin (Hb). The patient was transferred to a ward and was reported as showing improvement in their condition. The results of tests showed a low Hb, which can be an indicator of blood loss, though they remained clinically stable. There was no follow up treatment based on this result.

Three days after admission the patient passed a large amount of blood per rectum (PR), and though a slight drop in blood pressure, they remained clinically stable. Following review and appropriate management the decision was made to refer to the gastroenterology unit and undertake an endoscope (view the stomach and bowel to locate source of the bleed).

Later in the day more bleeding occurred and an urgent scope to investigate the site of blood loss was ordered.

Transfer was arranged to the operating room (OR) for urgent scope/intervention. On arrival in the OR the patient was assessed as being clinically stable, and redirected to the endoscopy unit. Whilst waiting in this unit the patient passed a large volume of fresh blood and went into cardiac arrest as a result of hypovolaemia (blood/fluid loss). They required immediate transfer to OR and following resuscitation, oversewing and closure of a large stomach ulcer. The patient required 2 weeks in ICU before being transferred to a rehabilitation unit.

What were the major contributing factors in this case?

The investigation found that despite alerts to a potential blood loss (low HB) no immediate management/investigation was ordered until it became an emergency situation.

Because a number of units were involved, no one unit was clear as to who had final management decisions on this patient.

How did the health service address these issues?

- That one unit take responsibility for coordinating care when dealing with patients with ongoing chronic and complex medical needs involving a number of clinical units. That being the unit with which the patient presents with active symptoms.
- Protocols/Procedures were developed for;
- Management and recognition of haematemesis and melaena in emergency, and other units.
- Management of emergency patients in OR until formal management plan is drafted.

How does your organisation coordinate its care of patients when several clinical specialties are involved in the care?

Root Cause Analysis (RCA) Education Program - Update

Module 1 and 2 of the RCA education package has been provided to a large number of rural and metropolitan health services staff. Attendees have ranged from junior nursing, medical and allied health staff, to senior clinicians and management representatives. Feedback has been positive. Module 3 education will commence rollout in June, and continue through July and August.

Lessons from the Sentinel Event Casebook continued…

A patient consented for an examination under anaesthetic of both ears, and a surgical procedure on the right ear. They had previously had corrective surgery on the left ear, and this required review with the right ear requiring treatment.

The patient was admitted as a day procedure and was running late on arrival to the day surgical unit. As a result of this the patient was not seen by the surgical team until in pre operative hold, where the surgical registrar quickly examined the patient and discussed surgery and site. The right ear was then marked.

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Both ears were examined and the procedure was carried out on the left ear. During the procedure the registrar did not pick up the wrong side error, as she was concentrating on the training and education being given by the consultant.

As the surgeons were finishing the operation it was noted on the medical record that consent was for the right side not left. This was discussed and procedure was then undertaken on the correct side, whilst the patient was still anaesthetised.

Following the surgery, the error was discussed with the patient. Although there was no serious outcome, the patient was under anaesthetic for a longer period and required an overnight admission to monitor recovery.

What were the major contributing factors in this case?

- There was pressure to proceed due to time constraints, starting with the late arrival of the patient.
- There was a departure from normal practice where the consultant would review the patient and notes, including consent, prior to proceeding.
- Patient was consulted, and verbal consent checked in pre operative hold area. Patient felt stressed had difficulty concentrating, and felt 'rushed', so was compliant.
- Consent not sighted on form, only verbal confirmation gained.
- Failure to look for marked site of surgery – both ears were being examined; only one was having the procedure done to it.

How did the health service address these issues?

Ensure Correct Site Surgery protocols followed, including;

- Confirmation with patient on site of surgery.
- Visually check consent form for accuracy.
- Note with other team right patient, right site right surgery on checklist.
- Visually note marked site for surgery – no mark no surgery.

Education to all staff reiterating Correct Site Surgery protocol.

Quarterly audits and reports to Safety committee on compliance and identify issues – aim is 100% compliance.

How are you evaluating the impact of the Correct site surgery protocols within your within your health service?

Health services will be required to provide an update on the effectiveness of implementation of this protocol to the department by mid July.

Review of Better Safer Transfusion Practice in Victorian Hospitals

Blood and blood products transfused in Australia are now extremely safe. Current transfusion risks largely relate to clinical practice issues, including the decision to transfuse and how products are administered.

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.

Key issues for better, safer transfusion:

- Is the transfusion necessary?
- Have I carefully checked the patient's identity?
- Is this the appropriate product for the patient's situation?
- Am I following my hospital's protocols for transfusion, including documentation, administration and management and reporting of adverse events?
- Has there been a discussion with the patient about the risks and benefits of transfusion? Have all their questions been answered?

Materials and suggestions for approaches that help support the delivery of better hospital transfusion practices are available at www.health.vic.gov.au/best.

Targeted desk and clinical audits are currently being conducted in public and private hospitals across the state looking at:

- Blood product administration, policy, procedures and practices
- Red cell use in orthopaedic surgery
- Clinical audit of fresh frozen plasma use
- Blood storage and handling

The utility of data collated by these audits will be greatly strengthened if the Hospitals Transfusion Committees (or the equivalent Clinical Governance oversight) actively participate in these audits.

The BeST Advisory Committee welcomes questions and comments on these audits.

Contact Karen Botting,
BeST project officer on 03 9349 4026
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Quote of the month

"We must not, in trying to think about how we can make a big difference, ignore the small daily differences we can make which, over time, add up to big differences that we often cannot foresee."

Marian Wright Edelman

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