Risk Watch

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Lessons from the sentinel event casebook

Potential for Error – Procedures and Guidelines

Patient A, admitted to the intensive care unit (ICU), required a blood transfusion following surgery. A sample of blood for cross matching was taken, and the doctor went to the central workstation to label the specimen with labels from this patient's history. The doctor inadvertently used labels from another patient's history (with a similar name – 'patient B'). The incorrectly labelled sample was then sent to pathology for processing.

On the same morning, patient B also required a blood transfusion. A blood sample was taken, correctly labelled and sent for processing.

The nursing staff received a unit of blood from pathology and administered it to patient B as per the attached label. They did not know it was the unit that had been cross-matched against patient A.

The nurse caring for patient A rang pathology to enquire where the blood was for their patient. Pathology stated that they had not received a request for patient A and that they had only received requests (two) for patient B. The error was then identified.

The transfusion was ceased immediately and fortunately the blood was of the universal donor type and compatible with patient B and thus ABO incompatibility (a life threatening condition) did not occur in this instance.

Samples were taken from both patients again and new transfusions prepared.

What were the major contributing factors in this case?

- Patient A and patient B had similar sounding names and had both recently had cardiac surgery.
- It is common practice to label samples at the nurses' desk, as this is a central point where patient history's and identification labels are kept.

How did the health service address these issues?

The organisation's guidelines for Blood Specimen Collection clearly states that samples must be labelled at the bedside immediately when taken. The organisation responded to the incident by;

- Undertaking an observational study to determine the nature of the informal practices of labelling blood samples and to then challenge and eliminate non standard practices.
- Created an awareness campaign for all appropriate staff as to patient identification policy's and guidelines for the collection of blood specimens.

What are your organisations policy's regarding patient identification and blood specimen collection? How do you ensure your staff practice accordingly?

STIR – Serious Transfusion Incident Report

The Department of Human Services Better Safer Transfusion (BeST) Program has developed a Serious Transfusion Incident Reporting (STIR) System to capture serious hospital transfusion incidents, including near-miss events. A near-miss event is defined as any error, which was recognised before a transfusion took place but which, if undetected could result in the determination of wrong blood group, or issue, collection, or administration of an incorrect, inappropriate or unsuitable blood component.

The system is designed to capture ten defined categories of serious transfusion incidents. These are:

1. Incorrect blood component transfused
2. Acute transfusion reactions
3. Delayed transfusion reactions
4. Transfusion associated graft-versus host disease
5. Transfusion-related acute lung injury
6. Post-transfusion purpura
7. Bacterial contamination
8. Post transfusion viral infection
9. Wrong blood in tube (near-miss event)
10. Other near-miss events

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Lessons from the Sentinel Event Casebook continued…

The system will be piloted over a three-month period in seven hospitals throughout Victoria, and then introduced state-wide in January 2007.

For more information please contact Lisa Stevenson at the BeST program on 9096 0476 or for more information on the BeST program visit www.health.vic.gov.au/best/

Potential for Error – Procedures and Guidelines

A patient slipped at home and presented to the emergency department (ED) with a sore neck and weakness in their right arm. A CT scan showed moderate injury to the patient's cervical spine (neck). The ED consultant requested an MRI (a special detailed X-ray), however the radiology department was unable to accept the request until the orthopeadic registrar had reviewed the patient. The orthopaedic registrar was in the operating theatre and unable to review the patient until later that day. At that point there was some debate as to the degree of the injury and actual diagnosis, an urgent MRI scan was ordered to better identify the level of injury, and provide a more definite diagnosis.

A miscommunication as to the availability of the hospital's MRI scanner meant that the patient was to be transferred to another hospital. The registrar was asked to organise the transfer and need for possible surgery.

The registrar rang a number of tertiary hospitals but was unsuccessful due to lack of beds, and disagreement as to the patient's diagnosis and presenting symptoms. The registrar referred back to the ED consultant and the patient was transferred to ICU for the night.

Because the patient's observations overnight were stable they were not reviewed until the following morning. An MRI scan was completed that showed substantial cervical spinal compression. The patient underwent urgent surgery to correct this and required extensive hospitalisation and ongoing rehabilitation.

What were the major contributing factors in this case?

- The hospital's MRI scanner is managed by a private radiology service and was only newly installed. Some staff were not aware of its 24-hour availability.
- The radiology department would not accept an MRI referral without orthopaedic review.
- The task of organising the patient's transfer was delegated to a junior medical officer.
  A consultant may have been more successful in emphasising the patient's condition and possible diagnosis when negotiating the transfer.
- The registrar was not aware of the option to refer to the neurosurgeon on-call when clinical disputes occur.
- Staff were unaware of the hospitals transfer agreement with a major hospital for acute spinal patient's, regardless of bed status.

How did the health service address these issues?

- The hospital and the private radiology service reviewed their communication processes in relation to availability of radiological services.
- The hospital and the private radiology service reviewed the requirements for requesting radiological investigations.
- All relevant staff were briefed as to the appropriate channels when negotiating with other organisations.
- All transfer requests to other hospitals are to be undertaken by the relevant consultant.
- Review of trauma triage guidelines to ensure all staff are familiar with requirements, especially in relation to suspected spinal trauma.

Do your staff know where and how to seek help and support when diagnosis disputes occur?

Are staff aware of all transfer of care policy's and processes?

Cervical Spine Acute Care Guidelines

In 2003 the Department of Human Services Clinical Risk Management Reference Group asked the State Trauma Committee (STC) to provide a statewide solution that would address the management of cervical spine injuries. After a detailed and consultative process, a guideline has been developed to address the management of both adults and paediatric patients. A state-wide education program is currently being developed.

The 'Cervical Spine Acute Care Guideline' was endorsed by the STC in February 2006 and is available at www.health.vic.gov.au/trauma/guidelines.

2006 Victorian Public Healthcare Awards

After a successful debut last year, the Department of Human Services is now calling for entries in the 2006 Victorian Public Healthcare Awards.

This year there are 10 categories plus the Minister's Awards for outstanding staff achievement and the Premier's Awards for the most outstanding health services of the year.

The Awards categories represent important areas of practice across the healthcare spectrum, regardless of the setting, service or specialty, and are open to all Victorian Government funded healthcare providers.

All the information you need to enter the Awards is available online at www.health.vic.gov.au/healthcareawards

Quote of the month

We must become the change we want to see in the world.

Mahatma Gandhi (1869 - 1948)

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