

Risk Watch

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Lessons from the sentinel event casebook

Potential for error – education and training

In a busy endoscopy unit, a gastroscope (special tube to view the stomach) was used on another patient without being sterilised between the two cases. The scope had been cleaned but had not been sterilised.

What were the major contributing factors in this case?

The investigation found that there were a number of factors that contributed to this event, including:

- Human Resources:
 - Not all staff were trained in the management and handling of sterilisation equipment.
 - When the unit was busy staff not familiar with equipment would assist theatre staff by processing and removing equipment.
 - There was pressure on staff to proceed even though all checks had not been finalised including paperwork to verify the equipment had been properly processed.
- Procedures/guidelines were not followed:
 - Standard cleaning and disinfecting guidelines in line with Australian Standards AS4187 were not followed.
 - The data log (paper readout) was not kept with the scope which indicated it had been completely processed.
 - The paper readout from the steriliser, which corresponds with the equipment and disinfection process, was not checked at the time of the procedure.
- Equipment:
 - There was not sufficient equipment for the workload in the unit, requiring the quick cleaning and turn around of equipment between patients.

How did the health service address these issues?

- The organisation developed a set of education and competency tools to ensure that all theatre staff are familiar with sterilisation practices, and equipment in the unit. Annual staff appraisals are undertaken to ensure they maintain and update this knowledge and practice.
- The organisation purchased more scopes, to reduce the need for rapid turn around on equipment.
- Theatres defined clear roles for staff working in the unit so that all staff were aware of their roles and responsibilities in relation to cleaning and sterilising equipment.

How does your organisation address cleaning and sterilisation practices within your health service?

Potential for error – assessment

A patient with a history of anxiety and depression was admitted to a general unit for a minor operation, and a routine surgical admission was completed.

The patient was being managed for their depression by their local doctor and was considered to be emotionally stable. At the time of admission the mental health issues were not considered to be of concern.

The day after the operation the patient was found in the bathroom collapsed after having attempted to hang himself from the shower rail. They were transferred to a secure mental health facility for further management and treatment.

What were the major contributing factors in this case?

The admission focus was on the surgical procedure. The patient was not fully assessed at the time of admission to address any mental or emotional issues.

The unit was unfamiliar with mental health patient's care and assessment.

The physical environment was not considered to be safe. In most clinical units potential self-harm structures, in this case shower rails, are modified to ensure patient safety. This means that should a patient attempt self-harm the rail would break, as they are not load bearing rails.

Lessons from the Sentinel Event Casebook continued...assessment

How did the health service address these issues?

- The organisation reviewed all clinical areas to ensure that patient environments were made safer.
- Review of admission processes to include an emotional and mental health assessment.
- Closer liaison with general practitioners, and other health providers to ensure complete history is provided at time of referral.
- Staff education to include mental health issues and management of patients with mental health needs.
- This included a plan to replace bed curtains, shower and towel rails, as areas are refurbished, to non-weight bearing rails. A review of any potential self-harm points will be undertaken to make staff aware of possible risks in the ward environment.

How does your organisation manage mental health issues within your health service?

Sites of interest

The Victorian Medication Advisory Committee

This website update is almost complete. Please visit: www.health.vic.gov.au/vmac to see the latest news and updates.

The revised website has new features including:

- The "Standing Order" repository
- The latest information about the National Inpatient Medication Chart (NIMC)
- The latest updates to the Register of Emergency and Life Saving Drugs

Please note that the VMAC website email contact is now vmac@dhs.vic.gov.au

Consumer Participation

In collaboration between the Health Issues Centre and the department,

a new guideline on *Participation indicators* has been published. The aim is to provide a resource to develop consumer participation performance indicators. More information can be found at: www.health.vic.gov.au/consumer

Topics of Interest

Root cause analysis (RCA) education

Where to from here?

Over 650 health service staff from 125 organisations have now attended the RCA education program.

Peer support groups for module 3 participants are now being established to allow organisations to share their experiences, and as a support for RCA facilitators.

Further education sessions will be provided in 2006 for health services who were unable to attend or under-represented. Private health services will be invited to participate in these courses.

Open disclosure update

In October representatives from each of the 12 Victorian pilot sites attended a training workshop conducted by the Cognitive Institute, on mastering open disclosure.

Workshops were designed to educate clinicians in talking to patients when things have gone wrong, and how to support other hospital staff in this process.

Each participant was required to act out the discussion with a 'patient' who had experienced a specific scenario.

Actors played the role of patients to give the experience a reality based focus. This process enabled participants to practice their communication skills in a controlled environment.

All pilot sites have now developed policies, which incorporate open disclosure in their clinical incident management processes.

Key performance indicators have been developed to assist pilot sites monitor their performance.

The new Australian Commission on Quality and Safety will progress this work from January 2007.

What is Failure Modes Effect Analysis (FMEA)?

Creating change that reduces the risk of failure can only be made through systems improvement. FMEA is one of the ways in which systems can be improved. This process is proactive (before the event occurs) rather than reactive (in response to an event). Although its roots are in engineering and manufacturing, the application of this process to healthcare is gaining momentum. The process encourages organisations to look at their systems and identify where failures could occur, and identify the extent of the effects of the failure. The process encourages barriers and change to systems before events occur. For more information on this topic visit the Veterans Health Administration, Center for Patient Safety web site: www.patientsafety.gov/HFMEA

Quote of the month

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

Mahatma Gandhi

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