

# Risk Watch

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## Lessons from the sentinel event casebook

### Potential for error – procedures/guidelines

A man presented to the Emergency Department (ED) following a 'probable' fall at home. He had been drinking and was clearly intoxicated on initial examination by the ED doctor. He was assessed as a 'query head injury' and was aggressive and restless in the emergency department. Security staff had to be called to restrain him and return him to bed as he was at risk of self-harm. His initial head injury observations were difficult to gauge due to his intoxication, though he appeared responsive and oriented.

He eventually settled, and on observation 30 minutes later was found on the floor, and was difficult to rouse.

A CT scan (Xray of his head) was taken, which showed a subdural haematoma (a bleed into the brain), and he required urgent neurosurgical assessment and operation to relieve pressure and remove the blood clot.

He was admitted to ICU and required extensive rehabilitation on discharge.

### 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:

- Procedures/guidelines were not followed:
  - In assessment of head injuries it is difficult to assess the severity of injury when the patient is intoxicated and uncooperative. Signs and symptoms may be masked or absent in this group of patients.
  - The initial disturbance and need for security staff to attend to this patient disturbed the usual sequence of events and assessment.
  - A CT scan would have identified any possibility of an intracranial bleed.

- Human Resources:
  - Staff were busy trying to cope with other patients as well as the aggressive and uncooperative behaviour of this man. Once the patient had settled they were reluctant to disturb him.

### How did the health service address these issues?

- Ensure all aspects of head injury assessment are completed, including X-ray.
- Ensure all restless patients receive close monitoring, and in circumstances are 'specialled' – nursed one to one.
- Provide height adjustable beds to enable at-risk patients and to ensure that they are managed close to the ground to prevent further falls risk.
- Educate staff about risks associated with masking of symptoms when patient's mental state is altered due to alcohol and or drugs.

### How does your organisation manage aggressive and or uncooperative patients?

#### Pharmacy alert

From MedWatch – The Food and Drug Administration (FDA) Safety Information and Adverse Event Reporting Program;

'Novo Nordisk Incorporated and FDA notified pharmacists of an initiative implemented to help prevent dispensing errors. To facilitate the dispensing of the correct product, color branded labeling has been introduced for NovoLog Mix 70/30, a premixed insulin analog, and NovoLog, a rapid-acting insulin analog. The previous box for NovoLog Mix 70/30 was white with a blue band. The current packaging for NovoLog Mix 70/30 is very similar and remains white with a blue band. The packaging for NovoLog previously was also white with a blue band. The current packaging is now white with an orange band. It is important that all pharmacists carefully distinguish insulin formulations by name and NDC number when dispensing.

Read the complete MedWatch 2005 Safety summary at: [www.fda.gov/medwatch/safety/2005/safety05.htm#NovoLog](http://www.fda.gov/medwatch/safety/2005/safety05.htm#NovoLog)

## Lessons from the sentinel event casebook continued...

### Facilities management

During a routine maintenance check of a hospital's gas supply and equipment, there was a sudden and short loss of oxygen supply to the hospital's key areas of Intensive Care Unit (ICU) and theatres (less than a minute). A code yellow (emergency response) was called and standby portable oxygen cylinders were used during the disruption. However, in one theatre the cylinders were not where they should have been and this meant a further 1-minute delay in supply being maintained.

Patients were not harmed, but the lack of communication of testing meant no one knew what was happening. There was staff confusion as oxygen alarms were activated in ICU, and some patients required manual ventilation during the brief period.

There was the potential for serious harm to one patient in theatre at the time, which was further compromised when the back up oxygen cylinder was not in its usual place.

### What were the major contributing factors in this case?

On investigation all due processes were followed in the maintenance yard and engineering, with the exception of notification to the critical areas about a possible interruption to oxygen supply, to enable units to ensure adequate backup was accessible if required.

Emergency back up equipment (oxygen cylinder) was not maintained/returned to correct place in theatre.

### How did the health service address these issues?

A thorough investigation found a potential fault with a gauge part, and all gauges have since been replaced. It is now mandatory that prior to any potential disruption of gas supply that critical clinical areas are given at least 30 minutes warning. This allows them to ensure they have appropriate back up in place, and they can respond rapidly.

It also ensures staff are informed of what is happening, and there is no unnecessary panic.

Each critical unit now undertakes regular checks to ensure that all emergency equipment is functional and in the correct location.

*This is considered to be a vital component of quality and safety in critical areas, and should be completed at the commencement of each shift.*

### How does your organisation manage environmental issues within your health service?

#### Ensuring correct patient, correct site, correct procedure update

The clinical risk management reference group have made a recommendation that all health services expand these guidelines to include all areas where patients receive treatment or undergo procedures, such as pathology, radiology and outpatient departments.

#### Sites of interest

The National Patient Safety Agency, BMJ Publishing Group and the Institute for Healthcare Improvement (IHI) have created a partnership to establish a new web site on patient safety resources; [www.saferhealthcare.org.uk/ihi](http://www.saferhealthcare.org.uk/ihi)

Initial topics for discussion are;

- Patient identification
- Safety culture
- Patient discharge, and
- Medication practice.

There are also great links to real stories from medical staff, and expert opinion and advice on medical error, and the lessons from them.

#### What is 'safer systems saving lives'?

This is a national collaborative of 52 hospitals initiated by the Australian Council for Safety and Quality in Health Care. The aim of the Safer Systems – Saving Lives project is to engage hospitals throughout Australia in a commitment to implement six proven interventions to improve patient care and prevent avoidable deaths.

The interventions utilise a 'bundle' model of care. This model builds on the concept that, whilst each intervention is of value, if all elements of the 'bundle' are used, the prevention factor is increased.

The Quality and Safety Branch of the Department of Human Services in Victoria will provide organisational lead and overarching project management. Commencing in October 2005 the project will be implemented in hospitals across Australia over approximately 12 months.

Safer Systems – Saving Lives project is based on the 100,000 Lives Campaign, an initiative by the Institute for Healthcare Improvement. Through the implementation of the six interventions the 100K campaign aims to avoid 100,000 deaths by June 2006, and every year thereafter.

There are six key interventions based on evidence shown to improve health outcomes and known to prevent harm to patients if systematically applied across organisations. These are:

- Preventing ventilator-associated complications
- Preventing surgical site infection
- Preventing central venous catheter associated bloodstream infection
- Improving medical emergency response
- Preventing adverse drug events
- Improving care for acute myocardial infarction

For more information check out; [www.health.vic.gov.au/sssl](http://www.health.vic.gov.au/sssl)

### Quote of the month

We are what we repeatedly do. Excellence, then, is not an act, but a habit.

*Aristotle, Greek philosopher*

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