

Risk Watch

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Lessons from the sentinel event casebook

Potential for Error – communication issues – non english speaking patient – near miss

An elderly patient was referred by their general practitioner (GP) for a cardiac procedure. Due to the history of heart disease and other health issues, the patient was evaluated at a pre admission clinic.

The patient was of a non-english speaking background, and their son acted as a translator. During the anaesthetic evaluation, the son indicated that the patient had had a previous admission for the same procedure and had experienced a severe cardiac event. On review there was no record of this in the patient history, though the son was certain.

Upon further investigation it was identified that the wrong date of birth had been provided, and the electronic medical record system had not accurately identified the patient and had generated a new record.

The correct date of birth was entered and the full patient history was retrieved.

Appropriate medical caution was taken and the admission proceeded without incident.

What were the major contributing factors in this case?

- The patient had not been flagged as from a non-english speaking background and a translator had not been pre booked. Had the son not been available the oversight may not have been identified
- Only minimal information is required as a patient identifier in the electronic system
- The lack of a streamlined referral process resulted in ambiguity of required information
- The clerking process on arrival in pre-admission clinic did not flag that the details were incorrect, possibly due to language difficulties

How did the health service address these issues?

- By ensuring that patient demographic information requested is in appropriate alphanumeric format i.e.; 1 Feb 1971
- The Divisions of Surgery & Medicine undertook a review of the referral process
- An automated interpreter booking system was introduced
- A form that requires all patients to verify their demographic details is now included in all correspondence from the booking office to patients

What is the minimum requirement of patient information required when booking patients for procedures in your organisation?

What is your organisations cultural diversity plan and how do you manage patients from a non-english speaking background?

Alert

An increasing number of reports analysing sentinel events in the Victorian healthcare system identify issues associated with electronic medical records as a contributing factor.

While technology allows for the efficiencies of electronic note taking it is important to ensure appropriate and complete information is entered into any database and that all users are fully trained in their functions.

Data/information extracted from electronic systems is only as good as the data that is entered.

Health Service Cultural Diversity Plans

The Victorian Government recognises that health services face particular challenges in ensuring that Victorians who are from culturally and linguistically diverse backgrounds enjoy the same access to high-quality health services as the broader community.

By June 2006 all Victorian health services were required to have established a cultural diversity committee with the specific aim of developing and implementing an organisation specific plan to meet its cultural and linguistic diversity needs.

Lessons from the Sentinel Event Casebook continued...

From 2007, all health services will be required to report annually on their plan's accomplishments through their Quality of Care report.

For more information go to the website at; www.health.vic.gov.au/cald/hlth_service.htm

Potential for Error – Post-operative observations

As a result of coronial investigations of cases of peri-operative mortality following surgical procedures, the Coroner made strong recommendations for the various medical colleges to develop a universal post-operative order form to accompany the patient through all stages of treatment and to be used by all hospitals in Victoria and potentially nationally.

A number of events reported to the sentinel event program have been associated with the effectiveness of post-operative clinical observations.

Contributing factors have included a lack of medical orders dictating which clinical observations should be taken and/or a lack of clear post-operative plans of care. These include no clear acceptable and reportable variations of patient observations, such as blood pressure limits, and whom to contact if there are concerns.

Other events have identified the lack of clear communication strategies (including unclear writing or reliance on verbal instructions) and assumptions of the existence of appropriate guidelines and procedures for post-operative observations.

The department supports work being undertaken by the Victorian Surgical Consultative Council (VSCC) and the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) to improve patient safety, in relation to universal post-operative orders.

In May 2005 the VSCC received funding to engage a contractor to undertake a project to develop a set of universal post-operative order principles. A more detailed report and documents can be viewed at the website; www.health.vic.gov.au/vscc/post_operative

The final report included the following universal post-operative order principles:

1. Post-operative orders are required for all invasive procedures
2. Clear policies and guidelines should exist to support the implementation of post-operative orders
3. Standard tools should exist to support implementation of the *policies* and guidelines regarding post-operative orders
4. A standard format and form for post-operative orders is required for all procedures and should provide an 'at a glance' overview of the full management plan until the next medical review
5. Medical staff writing orders should have:
 - Knowledge of the procedure, the expected post-operative course and of potential procedural complications
 - Knowledge of the patient's condition in relation to the intra-operative course, the patient's pre-existing co-morbidities and their risk factors for developing complications
 - Understanding of the environment (staffing, facilities) in the location where the patient will be managed post-operatively
6. Communication of post-operative orders must be written and verbal, with sign-off by staff making the orders and receiving the orders in theatre, recovery and ward area
7. Criteria for escalation of care need to be incorporated into the post-operative orders

8. Staff responsible for acting on post-operative orders are responsible for ensuring they receive written documentation of the orders, a verbal handover and for clarifying instructions before accepting care of the patient and for escalating care when indicated
9. Post-operative orders need to include both post-anaesthetic and post-surgical orders. While anaesthetic orders specific to the recovery room may be written on the anaesthetic record, anaesthetic orders or instructions pertinent to the ward need to be recorded as part of the general post-operative orders

Further work is being undertaken by the VSCC to develop and pilot a post-operative order form(s) for use across different health services. This second project will also include a process for implementation and guidelines for use, and is expected to be completed in early 2007.

If you have any questions related to this please contact either Ms Deanne Needham, Project Officer VSCC on 9096 1382, or Mr Deane Wilks, Program Manager on 9096 7916.

Quote of the month

Life expectancy would grow by leaps and bounds if green vegetables smelled as good as bacon.

Doug Larson

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