

## Lessons from the sentinel event casebook

### Retained instruments requiring re-operation

A patient presented to the emergency department with pain and ‘burning’ sensation in their hip. The patient had undergone a hip replacement some weeks prior, though had been otherwise well on reviews prior to this presentation. An X-ray was taken which identified a short length of guiding wire in place. The patient was booked for a day procedure to remove the foreign body and recovered well.

Guide wires used in surgery may be required to be different lengths, and are often cut to size. Any wires used during surgery should be measured pre and post operatively to ensure completeness at the end of the case.

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

- The wire was not measured prior to insertion and on removal to ensure completeness at end of surgery.

#### How did the health service address this issue?

- All items involved in surgery are to be included on the surgical checklist.
- Where guide wires are used, all wires will be measured prior to, and post surgery to ensure completeness.

### Procedures involving the wrong patient or body part

Events relating to wrong side/site procedures continue to be the most frequently reported sentinel event.

For the current reporting year to date these events make up 40 percent of all notifications.

Fortunately, none have resulted in serious harm but the ongoing system and process issues identified remain constant.

Most events reported in this grouping have taken place in diagnostic and therapeutic radiological procedures.

In the majority of cases a simple ‘time out’ process would have prevented the events from happening. In ‘time out’ all theatre or proceduralist staff take a few minutes to check that everything is in order, including the correct patient, consent is signed and site is identified/marked.

In some cases there were events where marking the site with indelible ink was not practical. A solution in one service was to introduce a diagram on the consent form. This highlighted the side and site of the body where the procedure was to be conducted.

In other cases, it was purely misidentification of the patient, and on a number of cases this involved areas where patient labels were centrally located, rather than in individual patient medical records.

A patient's label was removed and placed on investigation forms meant for another patient.

Practices such as these that may seem to improve ‘workflow’ issues, may in fact lead to opportunities for error.

In 2006 the Department of Human Services (the department) wrote to all health services seeking a further roll out of the *Correct side, correct site protocol*, which includes the process of ‘time out’ to all areas where patients undergo procedures.

This includes radiology, pathology and day procedure areas and would require these areas to undertake a ‘time out’ process.

These protocols should be well established in Victorian health services, though require ongoing monitoring to ensure compliance.

These events are not unique to Victoria, and the trends in data are consistent nationally.

The Australian Commission on Quality and Safety in Healthcare (the commission) is currently drafting specific protocols and procedures for clinical areas other than theatre to assist in implementing this concept into these areas. These will be available from the commission’s website upon completion and approval.

In 2007 The Victorian Surgical Consultative Council reviewed current protocols and developed new guidelines which supersede all previous guidelines regarding correct side and correct site surgery released by the Royal Australasian College of Surgeons (RACS and the VSCC available at;

[www.health.vic.gov.au/vscc/downloads/correct\\_side.pdf](http://www.health.vic.gov.au/vscc/downloads/correct_side.pdf)

#### What were the major contributing factors in these cases?

- Absence of a coordinated time out process.
- Changes to operating/procedure lists.
- Bilateral pathology, ie both eyes are requiring cataracts, but wrong eye operated upon (consented for Left and had Right corrected).
- Failure to follow patient identification processes.
- Placing patient labels in a central location rather than in individual medical records.

#### How have health services addressed these issues?

- Implemented a formal time out process and ‘red card’ to signify all OK to proceed.
- Included diagram with markings of side and site on the consent form.
- Developed formal patient identification (ID) policy and procedures.
- Implemented the use of patient ID bands in emergency departments.
- Banned storage of patient labels anywhere other than in the individual medical record.

#### Does your health service have a formal time out process? Is this standardised and monitored?

#### How do you know how your service is performing in this area?

#### Where do the audit results get reported to?

#### How is patient identification managed in your service?

#### Do you store patient ID labels centrally?

## Lessons from the Sentinel Event Casebook continued...

After commencing a blood transfusion the patient became short of breath and distressed. The infusion was ceased immediately and the patient administered medications to reduce the reaction they were having to the blood transfusion, and recovered fully. On review the blood was found to be an incompatible blood group.

The investigation found that in the laboratory, the first blood group and cross match was undertaken by a scientist. Prior to release of blood for transfusion a second group check is performed by another scientist. In this case the second check had been completed by a student scientist, who had failed to detect the error. It is unknown to what extent this contributed to the actual event, but raised some concerns when managing students in the work place.

It is considered that students should be closely supervised and not responsible for issuing patient results.

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

- The work environment was busy and work volume high.

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

- Protocols introduced that ensure all students are supervised.
- Patient results are only issued by qualified staff.

### Could this happen in your unit?

### How does your service manage student placements?

## Update on sentinel event program

### Evaluating Risk Reduction Action Plans (RRAP)

When undertaking a Root Cause Analysis (RCA) report consideration should include a review date.

Health services are expected to review their sentinel events and associated RCA and risk-reduction plans (RRAP) at a local level through the board quality committee.

It is expected that each RCA will be reviewed at six- and 12-month intervals to ensure the correct issues were identified, and to monitor the effectiveness of the actions implemented. Such reviews and their findings should be regularly reported to the board quality committee, and through this committee to each health service board as part of their clinical governance responsibility.

Health services are encouraged to escalate the identified risks articulated in the RRAPs to their organisational risk registers to ensure the governance endorsed treatment plans are monitored effectively over time.

### Open Disclosure

The National evaluation of the Open Disclosure (OD) Pilot Project has been completed and is now available on the commission's website. Victoria is currently developing a toolkit to assist organisations implement OD. Education and training options are also being explored to support the rollout of OD statewide.

For further information go to;  
[www.safetyandquality.org/](http://www.safetyandquality.org/)

### Incident Information System (IIS) Project

In August 2007 the IIS project scope was broadened to include Consumer Feedback and Occupational Health and Safety (OH&S) incidents. Dedicated working groups from these additional areas have worked extensively with the project Advisory Group to develop a combined Data Dictionary to facilitate standardised incident, adverse event and near miss reporting for clinical, OH&S incidents and consumer feedback.

In preparation for formal system piloting during 2008/09, it has been deemed important to ensure the inclusion of these 2 new groupings is consistent with the IIS clinical data set trialled in Sept – Nov 2007.

A small representative group of acute and community health services will test the IIS incident classification model and severity rating methodology throughout April and May 2008.

Further information can be obtained from the IIS project website, available:

[www.health.vic.gov.au/clinrisk/iis](http://www.health.vic.gov.au/clinrisk/iis)

or by contacting Theresa Williamson  
IIS project manager on 9096 7258  
or [theresa.williamson@dhs.vic.gov.au](mailto:theresa.williamson@dhs.vic.gov.au)

## Announcing the new Statewide Quality Branch

During 2007 the Quality and Safety Branch conducted a comprehensive review of its role and functions with the purpose of developing a clear strategic direction to lead quality and safety improvement across Victorian healthcare.

Jim Birch Management Consultancy was contracted to conduct a landscape analysis and develop recommendations on the strategic role of the branch based on extensive consultations and a scan of the quality and safety landscape both nationally and internationally.

The new overarching purpose of the branch is to be the principal adviser to the Minister for Health and the Department of Human Services executive team for state-wide policy development, planning, resource allocation and monitoring of performance in relation to the systematic improvement of safety and quality in healthcare.

To better reflect the statewide mandate of the branch, as of the 1st February 2008, the branch has been renamed the Statewide Quality Branch.

Concurrently, across the department consideration has been given to a number of programs that would be better aligned with the role of the Statewide Quality Branch, specifically, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM), the Victorian Patient Satisfaction Monitor and the Private Hospitals Unit.

The new branch incorporates these three programs, with CCOPMM commencing from the 1 March 2008. A summary of the new structure is outlined below and reflects an emphasis on policy, strategy and system building.

Statewide Quality Branch Unit	Manager
Office of Director	Alison McMillan, Director
Clinical Councils	To be appointed
Clinical Information and Knowledge Management	Steven McConchie, Manager
Policy and Strategy	Cath Harmer, Manager
Private Hospitals and Non Emergency Patient Transport	Helen D'Offay, Manager
Quality and Safety Programs	Deane Wilks, Manager
Victorian Quality Council	Diana Quin, Acting Manager

The new management team will be developing a statewide quality strategic framework which will determine priority actions and strategies to meet the objectives of the branch.

We are currently updating the Branch intranet pages and further information can be found at; [www.dhs.vic.gov.au/rrhacs/statewide\\_quality/](http://www.dhs.vic.gov.au/rrhacs/statewide_quality/).

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