

Risk Watch

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Lessons from the sentinel event casebook

Procedures involving the wrong patient or body part

Case 1

A patient presented to the emergency department with a sudden onset of hemiplegia, facial droop and right-sided weakness. The patient had a history of aggressive cancer with metastases and was being managed at home prior to admission.

A computed tomography (CT) scan of the brain demonstrated a large left frontal haemorrhage and cerebral oedema with no midline shift. Following discussions with the patient's treating team, family and the patient, it was decided to surgically manage the patient's acute condition.

The patient was transferred to theatre the same day, where the initial set up including the insertion of intravenous access lines was prolonged. The consultant left the operating room instructing the registrar to commence the case and he would return. When the consultant returned, the registrar had marked and started the incision on the incorrect side.

This was identified promptly and the incision was extended to allow the correct procedure to occur. The outcome for the patient was an extended incision line.

What were the major contributing factors in this case?

- Final 'time out' checks were not completed; hence there was no verification of the side for surgery.
- A lack of preoperative marking resulted in there being no visual prompt against which to identify the side for surgery.
- A final check of the patient's images was not performed immediately prior to the procedure, due to the distraction of consulting on another patient's images preoperatively.

How did the health service address these issues?

- An extensive review of final 'time out' checks has been undertaken and a checklist developed that stages all the checks that occur and assigns responsibility to an individual at each point.

- A recommendation was made to establish a consistent method of marking the side for surgery preoperatively.
- A recommendation was made to identify and implement strategies to reduce interruptions and distractions pre and intra-operatively.

What else can be done?

- The Victorian Surgical Consultative Council advice on this case noted that RCAs should also be reviewed at health service Division of Surgery audit meetings.
- There is an expectation that sentinel events and root cause analyses are discussed at all health service quality meetings to ensure that lessons learned are shared.

Case 2

An outpatient (Patient 1) attended radiology to undergo an abdominal MRI. On responding to a call by staff for another patient (Patient 2), Patient 1 was taken through to the secure area and prepared for the procedure.

Following performance of safety checks Patient 1 underwent pre and post contrast scans.

Following the post contrast scans Patient 1 identified that their name was not that by which they were being referred to. At the same time the wife of Patient 2 identified to a second radiology staff member that her husband had already gone into the secure area when they were called for from the waiting room.

A confirmation of the identification of both patients was undertaken and the correct MRI scans completed.

What were the major contributing factors in this case?

- Selection of the wrong patient occurred because there was no confirmation of patient identity as per best practice. This was complicated by the patient responding appropriately to the incorrect name.
- The selection of the wrong patient remained undetected as a result of a number of factors: verbal communication of the patient's name to radiographer, assumption that the patient's identity had been confirmed prior to entering the secured MRI area, the patient was the only patient in the secure area and the patient continued to respond to the incorrect name.

Lessons from the Sentinel Event Casebook continued...

How did the health service address these issues?

- Embed best practice identity check procedure into MRI orientation
- Implement 'Time Out' in MRI: update MRI safety form to include time out check, provide education sessions to staff
- Update departmental procedure manual to include MRI patient preparation process steps.

Patient identification update

The use of standard patient identification labels and bands can assist in reducing incidence of patient misidentification.

The Australian Commission for Safety and Quality in Health Care has developed specifications for a standard national patient identification band. These specifications have been endorsed by Health Ministers for use in public and private health services throughout Australia.

Links to the standard and specifications can be found at; <http://www.safetyandquality.gov.au/>, under the programs tab on the web page.

Further work in patient identification is being developed by the commission and the department will keep you informed of progress and outcomes.

<http://www.health.vic.gov.au/vccamm/resources/special/hyperthermia.htm>

Clinical risk management in small rural hospitals

The Limited Adverse Occurrence Screening program (LAOS), funded by the Department of Human Services, supports Victoria's small rural hospitals and their attending general practitioners (GPs) to participate in a clinical risk management program.

Recommendations for system improvement

Between July 2007 and June 2008, 70 small rural hospitals sent 1281 records to 122 peer-reviewing GPs; 56 GPs attended 13 reference panels and 57 recommendations to improve patient care were made.

Hospital staff and GPs discuss the reference panel recommendations at the

local hospital quality forums then feed back to the general practice divisions the actions taken in response.

Recommendations are acted upon at general practice divisional level with education programs.

At the statewide level, recommendations are posted onto a website accessible by LAOS hospitals and reviewing GPs, as what has occurred in one small rural hospital may be relevant for others.

Themes of recommendations are pooled and presented to the Sentinel Events Subcommittee of the Clinical Risk Management Reference Group.

To date summaries have been presented regarding documentation; management and transport of acute mentally ill patients; advance care plans and palliative care issues; and patient transfer and communication between referring hospitals.

What else can be done?

- Ensure your hospital screens for adverse events and participates in a clinical risk management review process.
- Discuss recommendations at safety and quality forums with all interested parties represented.
- Report back on actions undertaken or the need for assistance to improve safety and quality.
- Continue statewide feedback to the relevant departmental committees.

LAOS website: <http://www.health.vic.gov.au/clinrisk/laos.htm>

LAOS on General Practice Victoria's website:

<http://www.gpv.org.au/content.asp?cid=12,30&t=Clinical%20Risk%20Management>

A case from the LAOS reference panel

An elderly patient with cardiac failure was admitted with cellulitis.

Treatment with antibiotics was complicated due to other medications being taken, which included the anticoagulant warfarin.

Warfarin requires ongoing monitoring especially when physical changes such as infection are present.

It is important to monitor what is termed the International Normalised Ratio (INR), a blood clotting test used to monitor warfarin therapy.

Target INR values range from 2-3 for most conditions, and there is an increased risk of bleeding above 4.

On day four the patient had an INR of 5.2, and it was not until day 10 another INR was undertaken with a result greater than 10.

Panel recommendation made:

All INR results should be interpreted in clinical context by the patient's own doctor, especially if out of the recommended range.

The clinician prescribing warfarin should take responsibility for ensuring that INR levels are monitored appropriately.

System Improvement Recommendations

All pathology services have a policy for bringing abnormal results to the attention of the treating doctor.

How does your organisation manage abnormal results reporting with your pathology provider?

Does your hospital have a warfarin management and discharge plan?

Warfarin management guidelines can be found at:

http://www.health.vic.gov.au/vmac/downloads/warfarin_guidelines.pdf

www.cec.health.nsw.gov.au/pdf/SSSL/li-verpoolwarfarin-guidelines-education-booklet06.doc

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