

Risk Watch

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Lessons from the sentinel event casebook

Procedure involving the wrong patient or body part

Case 1

An elderly man was admitted for elective surgery for removal of right cataract and intraocular lens implant. In preparation for surgery the incorrect (left eye) was anaesthetised. The error was identified and the procedure was performed on the correct eye.

It was not clear which consent form the anaesthetist reviewed prior to the commencement of the eye block due to the consent form from the previous month being contained within the same medical record.

How did the health service address these issues?

Reinforce that eye surgery is to be marked by the ophthalmologist or senior clinician as delegated by the ophthalmologist prior to the commencement of eye drop preparation in the Day Surgery Unit.

Staff to be re-educated and re-assessed in the process of 'team time out' in the Peri operative department and audits are conducted to ensure compliance.

Review the process of medical record for patients undergoing surgery which would include the content of the patients file going with the patient to the operating theatre.

The Royal Australian and New Zealand College of Ophthalmologist recommend;

- The site and side of the operation should be written in full (ie RIGHT or LEFT) and not abbreviated to R or L whenever the side is recorded.
- An indelible pen is used to unambiguously mark the eye/side of the procedure. This is done or checked by the surgeon in consultation with the patient and operative notes.
- The patient is informed that the pen mark indicates the side of the operation.

Ocular Surgery Guidelines for Ensuring Correct Patient, Correct Eye, Correct Site and Correct Procedure can be found at:

http://www.ranzco.edu/aboutus/ranzco-policies-and-procedures/policy/Correct_Eye_Surgery_Guidelines.pdf/view?searchterm=guidelines

Other catastrophic

Case 2

An elderly patient was admitted for the treatment of leg cellulitis. They had abnormal liver function tests and with increased confusion, visual hallucinations with a normal CT scan, tachycardia, tachypnoea, rigors and a temperature of 39°C.

The patient had an unwitnessed fall whilst in the Emergency Department (ED). An incident report was completed by the nurse in charge and the fall was documented in the ED nursing notes but there was no medical documentation.

On day three the patient's condition changed. The patient was reported to be slightly confused, febrile, tachycardic, hypertensive and shaking.

Intravenous and oral sedation was given and wrist straps were placed on the patient because they were delirious, a danger to themselves and others and had been climbing over the rails of the bed.

Restraint assessment observations were conducted every fifteen minutes until the wrist straps were removed after they had settled for a period of time.

The patient had an unwitnessed fall, their second for this admission, early in the morning. They were found on the floor after having climbed over the cot sides and walked a few steps.

The patient was reviewed by a medical officer. No further observation orders were ordered. One set of neurological observations was made after the fall. After breakfast the patient asked to return to bed. They were later found to be unresponsive. A medical emergency team was called, which progressed to a Code Blue and the patient was intubated on the ward.

A CT scan of the brain showed an extensive acute on chronic right subdural haematoma. They were transferred to ICU where brain death was later certified.

Lessons from the Sentinel Event Casebook continued...

What were the major contributing factors in this case?

- Although the patient's wrist straps were removed after a short period of settled behaviour they were still confused post removal, which potentially contributed to them climbing out of the bed.
- The patient was not assessed for falls risk in the ED, no falls prevention strategies were in place, which may have contributed to the first fall.

How did the health service address these issues?

- Review minimisation of restraint protocol to ensure it includes criteria for wrist restraint removal and requirements for monitoring a patient post-removal
- Emergency Department to review its compliance with existing guidelines for falls risk assessment and prevention. Audit results to be reported to the Falls Steering Committee with any applicable recommendations/actions to strengthen the guidelines and/or improve compliance.

What else can be done?

Although it may be appropriate in specific circumstances to use physical restraints, these should only be used after consideration is given to the reasons for restraint, the potential harm of restraint and what alternatives to restraint could be used.

Do you have a restraint policy and procedure in your health service that is consistent with the care process in aged care?

To find out more about the appropriate use of chemical and physical restraints visit:

<http://www.health.vic.gov.au/agedcare/services/score.htm>

A change to category one sentinel event definition

The category one definition *'Procedures involving the wrong body patient or body part'* has been amended to:

Procedures involving the wrong body patient or body part, resulting in death or major permanent loss of function.

This change was approved by The Australian Health Ministers Advisory Council after a recommendation from the Commission for Safety and Quality in Health Care.

The Department of Health supports this amendment, though still encourages significant near miss reporting for this category.

Victorian clinical governance policy framework

The Victorian clinical governance policy framework has been developed to guide health services to implement a framework or review and further develop existing frameworks.

The framework outlines four domains of quality and safety

- Consumer participation
- Clinical effectiveness
- Effective workforce
- Risk management

Within each domain there are a number of quality and safety management functions that require direction and oversight by governing bodies.

Under these domains all of the required principles of clinical governance should be addresses.

The guide and toolkit provides a practical framework through the use of checklists and key references to assist with reviewing the roles and responsibilities of key stakeholders within the health service.

The guide and toolkit is available at http://www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy.htm

Event Reminder

The VIMA Risk Conference will be held in Melbourne on 21 to 22 October 2009.

Visit the website to find out more about the first risk management forum designed specifically for the Victorian Public Sector.

<http://www.vmia.vic.gov.au/skillsEDIT/clientuploads/48/VMA%20Risk%20Conference%20Brochure%20Aug%2009.pdf%20Risk%20Concto>

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