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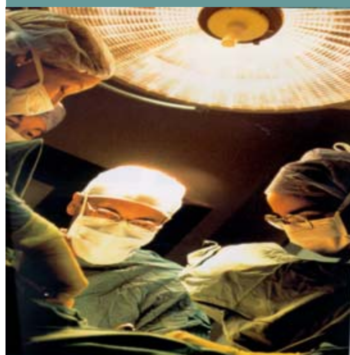


Office of Safety and Quality in Healthcare (OSQH)

SNIPt'S Sharing News in Patient Safety

Australian Incident Monitoring System **AIMS**

Western Australian public hospitals and health services collect and record incident data using the Australian Incident Monitoring System (**AIMS**).

AIMS is a voluntary system for reporting incidents and uses a single generic form to collect incident data to enable investigation, management and monitoring of potential and actual incidents. Each hospital is able to run reports on data entered at their site , enabling trends to be monitored on individual sites' data. Information for ***SNIPt'S*** is received from representatives from metro and rural health services who are responsible for coordinating **AIMS** in their institution. They are asked to submit patient safety initiatives arising from their analysis of local data. These initiatives are then included in the quarterly reports compiled by the Office of Safety and Quality.

If you would like to contribute to future editions of SNIPt's please contact Marece Bentley on (08) 9222 4080.

A word from the Executive Sponsor of AIMS

Welcome to the first edition of the Office of Safety and Quality's official quarterly newsletter. SNIPt'S is an acronym for Sharing News in Patient Safety and its objective is to bring you useful and timely information on patient safety news at a local, national and international level.

In addition to the regular SNIPt's newsletter, the Office of Safety and Quality in Healthcare is hosting an AIMS Seminar on Thursday 30 September. The seminar is an opportunity for AIMS users to share lessons learned, particularly around the successes and barriers of incident reporting at the local level. Professor Bill Runciman (Royal Adelaide Hospital) is the keynote speaker and will share his views on how incident reporting has improved patient safety. Professor Runciman pioneered incident reporting in Australia and is now a sought after international speaker. I look forward to hearing about the many exciting improvements that have been put into place. See you there!

Dr Dorothy Jones
Executive Sponsor AIMS

Invitation to AIMS Seminar 30 September 2004

Mark Thursday 30 September in your diary. The full day seminar will showcase initiatives arising out of AIMS. The Office of Safety and Quality in Healthcare (OSQH) will also be presenting Patient Safety Awards to those individuals who have excelled in the area of patient safety. Information on the seminar, including templates for submitting abstracts or Patient Safety Award nominations can be downloaded from the OSQH website at www.health.wa.gov.au/safetyandquality.

Please RSVP for catering by 24 September to

aimsinfo @health.wa.gov.au

Lesson one: Inactive alarm setting on Dialysis Machine

AIMS reports in one metropolitan area identified the potential for error to occur in the default set up of a KIMAL Hygieia Plus (Model 39300K) Dialysis Machine. The air detect alarms are rendered inactive whilst the machine is running in demonstration mode. Read on...

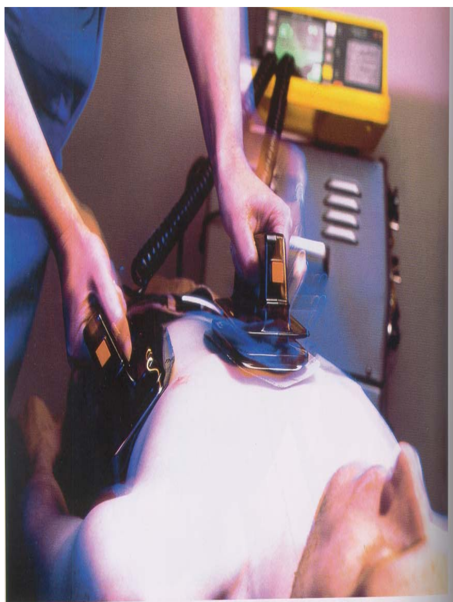
An incident involved a **KIMAL Hygieia Plus (Model 39300K)** Dialysis machine. Investigation of the incident revealed that it is possible for patient to be connected to this particular dialysis machine while it is set in demonstration mode as well as the operational/ clinical mode.

Running the dialysis machine in demonstration mode renders all the "air detect" alarms inactive, ie. if air inadvertently enters into the circuit it is not detected the alarm is not activated and the machine continues to operate. There is evidently a potential risk to patient safety should air enter into the system whilst a patient is connected to the machine.

The Therapeutic Goods Administration has been notified of this potential risk. Discussions with the manufacturer are underway to see if the machine software can be modified so that when the machine is turned on it will automatically default to the operational/ clinical mode with all alarms activated.

If your organisation has a KIMAL Hygieia Plus (Model 39300K) Dialysis machine please be aware of the potential for this type of error to occur.

Lesson Two: $ETCO_2$ when transporting ventilated, intubated patients



The inability to adequately monitor a ventilated patient's respiratory status during transportation resulted in a patient suffering a respiratory arrest. The literature identifies $ETCO_2$ as the gold standard for assessing respiratory status when transporting intubated, ventilated patients.

An incident was reported to a WA hospital in which an unconscious, intubated patient had suffered a respiratory arrest during transportation. Clinical investigation revealed that it was extremely difficult to adequately monitor a ventilated patient's respiratory status while en-route. Review of the literature (Royal College of Anaesthetists, Faculty of Intensive Care) found that End Tidal Carbon Dioxide ($ETCO_2$) monitoring is recommended as the gold standard for assessing respiratory status when transporting intubated, ventilated patients.

Following the investigation the Hospital Executive agreed to a number of system changes, including:

1. Modifying and standardising the hospital's policy to include $ETCO_2$ monitoring on all intubated patients during transportation;
2. Purchase additional $ETCO_2$ modules to meet current requirements; and
3. Increased education for all critical care staff to ensure knowledge &

More lessons Please...

Sharing lessons learned is extremely valuable to all those who work in clinical settings. If you have implemented anything in your workplace as a result of analysis of your own AIMS data, please let us know and we will publish your lesson learned. Please be assured that all information published remains deidentified. A template for submission is available on the OSQH website http://www.health.wa.gov.au/safetyandquality/program/aims/practice/index.cfm

If you would like to contribute please contact Sarah Zilko or Marece Bentley on (08) 9222 4080.

Lesson Three: Reducing distraction to prevent omission of medication

Omission of medication is one of the most common types of medication error. One local area identified distractions as a contributory factor and put in place several strategies to prevent this type of incident from occurring.

Review of AIMS medication data at one WA site, showed that the majority of incidents were omission of medication either not signed or not given. Investigation of these incidents using the Root Cause Analysis methodology identified a number of contributing factors that were not immediately apparent in the AIMS trended data. For example, nursing staff were using two systems for administration of medications – a drug trolley and a locked drawer. Basic drinking cups, clean medication cups and full water jugs were often not present resulting in staff going backwards and forwards to the kitchen interrupting the flow of administration. Nursing staff were also being interrupted due to answering phone calls. This was a problem particularly after 4.30pm as clerical staff had left for the day, leaving the front desk unmanned. The organisation implemented a trial in which clerical staff stayed on for an extra hour so that nursing staff could administer medications without telephone interruption.

Lesson Four: Triaging patients at risk of febrile neutropaenia—development of a patient held alert card

Febrile neutropenic patients often present to the hospitals' emergency departments and aren't recognised by triage staff as being at risk. As a result they have been made to wait in overcrowded emergency department waiting rooms or have gone home only to represent a number of times again before something is finally done. One hospital has developed a patient held alert card to facilitate appropriate triaging.

This problem of identifying patients at risk of febrile neutropenia was acknowledged at one WA hospital. The Clinical Nurse Consultant for Cancer Services consulted with Heads of Departments and Clinical nurses from both haematology and oncology to develop a febrile neutropenia alert card. This card is designed specifically for use by haematology and oncology patients to show to this hospitals emergency department triage nurse on presentation to the hospital when they are unwell after chemotherapy.

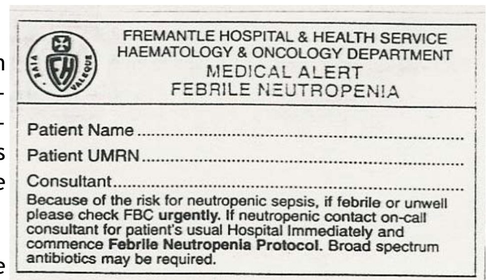
Just prior to implementing this card into the emergency department, a critical incident occurred where a febrile neutropenic patient presented to the emergency department and left the department without being seen on several occasions over a 3 day period. Unfortunately, the patient did not identify themselves as having recently undergone chemotherapy treatment. This, and the fact that they had not been treated as this particular hospital for cancer, resulted in the patient being triaged inappropriately.

To prevent this type of incident from occurring again it was decided to develop a metropolitan wide febrile neutropaenia alert card so that all patients at risk of febrile neutropaenia would be triaged appropriately.

Consultation with key people at the other large metropolitan cancer centres led to the development of a lilac coloured card with generic alert information on it, the patients' details (unit number etc) and their consultant information on it.

Each major hospital has printed their own alert cards with the hospital details so that triage staff can easily identify which hospital the patient is being treated at. This assists staff in accessing the relevant patient information in a timely manner.

There is now discussion whether patients presenting with the alert card are categorised as a Category 2 until their signs and symptoms are assessed at which stage there may be an adjustment of their category status be implemented in a timely manner.



FREMANTLE HOSPITAL & HEALTH SERVICE
HAEMATOLOGY & ONCOLOGY DEPARTMENT
MEDICAL ALERT
FEBRILE NEUTROPENIA

Patient Name ....

Patient UMRN ....

Consultant ....

Because of the risk for neutropenic sepsis, if febrile or unwell please check FBC **urgently.** If neutropenic contact on-call consultant for patient's usual Hospital Immediately and commence **Febrile Neutropenia Protocol.** Broad spectrum antibiotics may be required.

FREMANTLE HOSPITAL & HEALTH SERVICE
HAEMATOLOGY & ONCOLOGY DEPARTMENT

Oncology Clinic
Monday - Friday 8.30am - 4.00pm
Nurse 9431 2846
Haematology Clinic
Monday - Friday: 8.30am - 4.00pm
Nurse 9431 2203
Office 9431 2212
B91 Dav Ward
Monday - Friday: 8.30am - 5.00pm
Nurse 9431 2660
Ward B9 North
All Hours 9431 3333
Emergency Department
All Hours 9431 3333

Contact SNIPt'S : If you wish to subscribe to the SNIPt'S newsletter, please contact Sarah or Marece 9222 4080

aimsinfo@health.wa.gov.au

Lesson Five: Development of insulin infusion guidelines

AIMS reports in one rural health service identified a problem relating to the administration of insulin. Staff worked together to develop insulin infusion guidelines.

Investigation showed there was no guideline or chart available for use of insulin in the clinical unit and as a result the staff were not providing the safest possible care. This was impacting on patients and staff as well as the medical officers.

Analysis of the AIMS data demonstrated a number of contributing factors:

- No doctor signature on the insulin order;
- Varying prescriptions for insulin;
- Lack of team work; and
- Lack of confidence to seek help.

The nurses were aware and concerned that they were working in an unsafe environment.

As part of the investigation process staff undertook a literature review and consulted with staff in other clinical areas. This confirmed the evidence that an insulin infusion is the preferred choice for the intended clinical treatment.

A one page chart and guidelines regarding insulin infusion were developed and implemented. Over a period of six months both documents were refined and subsequently distributed throughout the region. Use of the documents has helped to make the administration of insulin safer.

A complementary strategy was to employ additional session physicians including a Diabetes Specialist from one of the metropolitan teaching hospitals.

These strategies have facilitated a shift from a nurse driven goal to a team approach that shares a common vision.

If you would like further information on any of the lessons learned in this publication, please contact Sarah.Zilko or Marece Bentley

aimsinfo@health.wa.gov.au

Erro Med Workshop

The Office of Safety and Quality hosted an ErroMed workshop at the Perth Zoo in June 2004.

Dr Darryl MacKender, gastroenterologist and Captain Don Wynne, Crew Resource Management (CRM) trainer and ex– Qantas pilot presented the Human Error and Performance Workshop over two days to clinicians from across the state.

Participants took away new insights to human error and had an enjoyable time participating in team building events.

The workshop evaluation revealed participants were particularly impressed by the Graded Assertiveness training and building good teams as demonstrated at this workshop.

In response to this feedback the Office of Safety and Quality will be developing a communication module to complement the existing RCA training. It is anticipated this module will be piloted and rolled out across state over the next 12 months.

Participants at ErroMed getting into some team building, June 2 & 3 2004

Journal SNIPt'S

A recent Australian study examined attitudes of medical and nursing staff towards reporting incidents. Read on….

A recent study by Kingston et al explored attitudes of medical and nursing staff from three metropolitan public hospitals in Adelaide towards reporting incidents (adverse events and near misses). Whilst the sample size was small (n=33) the authors claim that this is the first qualitative study to allow candid contributions from single specialty groups (consultants, registrars, resident medical officers, senior nurses and junior nurses).

Analysis of the focus group commentary demonstrated differential use of incident reporting by doctors and nurses which may be attributable to the different cultures of the two professions. Nurses work in a culture that responds to directives, protocols and the notion of security whereas the medical culture was less transparent, favoured dealing with incidents 'in house' and was less reliant on directives. Other systems factors also influence the decision to report incidents including time constraints, dissatisfaction with the process, inadequate feedback, and failure to value the process. The study also highlighted that there was some confusion about what should be reported, feelings of fear of retribution and doubts about the possibility of remediation.

Kingston MJ, Evans SE, Smith BJ and Berry JG. 'Attitudes of doctors and nurses towards incident reporting: a qualitative analysis'. *MJA* 2004; 181:36-39.