FALLS - RELATED DEATHS IN VICTORIAN HOSPITALS

The State Coroner has released an ‘investigation standard’ that all Victorian hospitals, public or private, must meet when they report a death that has occurred after a fall in hospital.

Information must be provided in four key sections: (1) the patient’s history; (2) the event and events leading up to the fall; (3) the facility’s system for falls management; and (4) relevant equipment or work practice. The hospital management will have to provide their policy, protocol and practice for falls risk screening, falls prevention, and falls management to the Coroner.

This highlights falls prevention as a systems issue, requiring a whole-of-organisation approach. Falls prevention is not the responsibility of any one professional group, and is not just a clinical issue. This is why the Department requires health services and hospitals to outline their falls prevention activities in the 6-monthly Clinical Risk Management reports.

The Coroner has sent the standard to all Chief Executives. If you have questions about the standard and its implementation, contact the State Coroner’s Office on (03) 9684 4444. If you would like more information about Victoria’s falls-prevention initiatives, please contact the project officer: Margaret.thomas@dhs.vic.gov.au

PICKING THE HEART OUT OF CLINICAL INDICATORS

Many writers have pointed out the need to establish objective criteria for medical practices and procedures. The Department collects clinical indicator information as one means of achieving objective performance assessment.

The Australasian Society of Cardiac Surgeons and the Department have recently released a public report on the Victorian Cardiac Surgery Database project. It looked at all adult cardiac surgery performed in Victorian public hospital Units from 1 August 2001 to 31 July 2002 against a variety of demographic characteristics.

The review compared performance across Victoria’s six public cardiac surgery units, and found that there were no significant differences in the performance outcomes between the individual units. Even better, the review showed that the outcomes from cardiac surgery in Victoria were as good as or better than equivalent overseas results.

Patient Safety is Our First Priority

LESSONS FROM THE SENTINEL EVENT CASEBOOKS

A patient underwent an invasive and complex biopsy in an operating theatre. The specimens were placed in a jar. At some stage the unlabelled jar was moved from the scrub table to a multi-use side table. The counts were completed and the patient was moved from theatre. The theatre was set up for the next patient. Later that day, the scrub nurse realised that the specimen jar had not been sent to Pathology. The Pathology slip was found under the next patient’s items on the multi-use table. The specimen jar was never found.

The reporting health service found the following root causes for the loss of the specimen jar:

- The specimen jar was removed from the scrub table to the multi-use table without the formal acknowledgement of the scrub nurse.
- An informal norm of omitting visual/verbal checking of the labelling of pathology specimens made it more likely that an unlabelled specimen could be placed on the multi-use table.
- An informal norm existed that allowed counts and pathology specimen data to be entered into the computer records prior to theatre. The practice was to change the data afterwards if a problem were found.
- No single place was designated for pathology samples once they left the scrub table.
- Staff were working short-handed due to staff illness. They had to carry out large counts as well as fit in a break and set up for the next case.

The health service has implemented the following system changes:

- A review of staffing processes to replace theatre staff when they are ill.
- Count and specimen data are not entered into computer records until the procedure is completed.
- A purpose-specific receptacle has been introduced into all theatres for all specimens leaving the scrub table, but not immediately going to pathology.
- Staff have been made aware of the requirement for visual and verbal handover of pathology specimens leaving the scrub table.

Remember the KISS principle, and keep processes simple and easily followed. In this case, it seems sensible that the scrub nurse takes responsibility for the specimen.

Web-site of the Month

www.fda.gov/cder/drug/mедер

For helpful information on medication safety and high-risk medications.

Read any good articles lately?

We recommend


“He who never changes his opinions, never corrects his mistakes, will never be wiser on the morrow than he is today”

Tyron Edwards (1809-94)