

# CLINICAL PROCEDURE SAFETY

## LEVEL 3 PROCEDURES: SIGN IN – CASE STUDIES

The case studies are provided as a resource for health care facilities to use during implementation of the Clinical Procedure Safety PD2014\_036.

Each case study is based on an incident reported to the Incident Information Management System (IIMS) and the action required is based on requirements from the Clinical Procedure Safety PD2014\_036.

### Case 1

#### Identifying the Patient

The nurse collected the patient's chart and verbally confirmed the patient's name and the intended procedure by stating most of the information herself, to which the patient readily agreed.

The nurse failed to check the patient's identification band.

At the end of the identification process the nurse positioned the patient on the operating table. The anaesthetist checked the patient's identification band and alerted the nurse to the fact that the chart in the theatre did not belong to the patient on the table.

#### ACTION REQUIRED

The anaesthetist, with another member of the procedural team, verbally confirms the patient's identity by:

- Asking the patient to state their full name, date of birth and procedure
- Confirming the patient's identity with the patient identification band and consent.

### Case 2

#### Monitoring the Patient

An elderly patient was admitted for bronchoscopy. No anaesthetist was present during the procedure. Two mg of Midazolam was administered intravenously. The patient became "like a rag doll" after administration.

The O<sub>2</sub> saturation dropped rapidly after the procedure commenced, recorded as 80% for five minutes before dropping to 74%. O<sub>2</sub> was administered 15 litres by nasal cannula. The doctors were advised of the oxygen saturations throughout the

procedure. The patient was noted to be poorly saturated and unresponsive when the bronchoscope was removed. A face mask was applied and an arrest call made.

An anaesthetic team took over management of the patient. The patient required respiratory resuscitation and admission to the HDU.

Ongoing management included BiPAP, sedation for agitation and intervention for respiratory and cardiac complications.

The patient died two days later.

#### ACTION REQUIRED

When procedural sedation is used, and where an anaesthetist is not present to care exclusively for the patient, a clinician other than the proceduralist must be nominated whose primary responsibility is to monitor the patient's level of consciousness and cardio-respiratory status.

### Case 3

#### Monitoring the Patient

A patient was admitted via the ED with a fractured right ankle. On route to the hospital the patient had been administered 15 mg of Morphine by ambulance officers, but the ambulance record was not located with the patient's notes.

The patient's ankle was immobilised in the ED after administration of 2.5 mg of Midazolam. The patient was then noted to be drowsy. Doctors reviewed and found the patient in pre-respiratory arrest (extremely drowsy, obstructing airway, respiratory rate of 4, oxygen saturations 80% in room air).

The patient had Naloxone and responded well.

#### ACTION REQUIRED

Continuous pulse oximetry and blood pressure monitoring must be started on the patient prior to commencing procedural sedation and continued until the patient is adequately recovered from this.

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## Case 4

### Confirming the Correct Implant

A patient presented to hospital for right cataract extraction and intraocular lens placement. The patient was scheduled fourth on the theatre list. The surgeon changed the order of the list and the patient was moved to second position.

The anaesthetic nurse verified the patient's identification and took the patient into the anaesthetic bay. The nurse informed theatre staff of the changed order of the list.

The surgeon selected the lens intended for the patient originally scheduled as second on the list. Sign In was conducted but did not include checking of the lens. The surgeon listened to the Sign In process but did not participate. The error was discovered when the third patient was brought to the theatre.

#### ACTION REQUIRED

A proceduralist must be present during Sign In to confirm that the correct implants are present and functional.

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## Case 5

### Patient Identification

When paediatric *Patient A* was called for surgery, *Patient B*'s family stood up and said they were *Patient A*. *Patient B* went into theatres with the anaesthetist and the child was anaesthetised. No patient check was performed.

On arrival of the surgeon, Team Time Out was conducted and it was noted that the patient had no patient identification band.

The surgeon did not consider this was the correct patient and the "site" marked for the procedure was not that indicated for surgery.

The mother of *Patient B* was brought back to theatres to identify the child; correct notes were brought into the theatres; and the child had an identification band placed on them.

#### ACTION REQUIRED

Patient identification must be completed before commencing general anaesthesia.

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## Case 6

### Confirming the Correct Side for Surgery

The patient required an open reduction and internal fixation of the left femur. The consent form stated fractured left neck of femur.

A femoral nerve block was put into the right femur by the anaesthetist in the holding bay. The error was realised that the femoral nerve block was inserted in the incorrect side.

A nerve block was inserted into the correct side (left). Open reduction and internal fixation was attended as planned with the operation completed on the correct side.

#### ACTION REQUIRED

Sign In One is completed by the anaesthetist in conjunction with another member of the procedural team by confirming:

- The planned procedure matches the consent
  - The side matches the consent.
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## Case 7

### Monitoring the Patient

A patient was admitted with an arrhythmia on a background of severe chronic respiratory illness and reviewed by the GP VMO for persistent atrial flutter. Treatment was provided. The patient's condition was discussed with the cardiologist and cardioversion planned.

Cardioversion was undertaken in the ED with procedural sedation. The GP anaesthetist left the patient under the care of the senior ED doctor shortly after completing the procedure.

The patient was slow to wake and another doctor in the ED noted that the patient's GCS was only 9 and that the patient was breathing inadequately, hypoventilating and having periods of apnoea.

The GP VMO attended and the patient was transferred to a tertiary facility, accompanied by the GP VMO (no retrieval team requested).

#### ACTION REQUIRED

When procedural sedation is planned, a patient sedation risk assessment must be completed before commencing procedural sedation.

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## Case 8

### Correct Implant Available

An elderly patient having a right knee replacement had a left knee femoral component of the prosthesis implanted into the right knee, requiring reoperation to implant the correct femoral stem prosthetic component.

#### ACTION REQUIRED

A proceduralist must be present prior to commencement of anaesthesia to confirm that implants (side) are determined and available.

The ICU consultant was subsequently informed by theatre staff that sulphur hexafluoride had been used inadvertently instead of CO<sub>2</sub>.

The patient underwent laparotomy and proctocolectomy for ischaemic transverse and descending colon. The requirement of the CO<sub>2</sub> gas had not been regarded as 'special equipment' and these gas cylinders were therefore not checked.

#### ACTION REQUIRED

The proceduralist must confirm that special equipment needed is available and functional before starting the procedure.

## Case 9

### Confirming the Correct Side for Surgery

An elderly patient was checked by the anaesthetic registered nurse in Day Surgery where the site was confirmed as the left eye. The left eye was marked and an eye pad was placed insitu.

In the anaesthetic bay the nurse confirmed the left eye was the correct site with the patient in the presence of the anaesthetist. Oxygen was applied and the patient was attached to monitoring as receiving sedation for the block procedure. The nurse noted that the saturation probe was not working and asked the anaesthetist not to commence the block.

The nurse returned to the bay, attached the saturation probe to the patient and was waiting to get a reading of the patient's saturation. While the nurse was adjusting the monitor and had her back to the anaesthetist, the block was attended. The nurse noted the block was in the patient's right eye. The anaesthetist and proceduralist were notified that the wrong eye was blocked.

#### ACTION REQUIRED

The anaesthetist, in conjunction with another member of the procedural team is to confirm:

- The planned procedure matches the consent
- The side matches the consent before starting procedural anaesthesia.

## Case 10

### Reviewing Essential Imaging

An elderly patient was booked for endoluminal aortic aneurysm repair. The surgeon completed a Request for Admission Form and reported that because of iodine allergy, the patient would require CO<sub>2</sub> gas as a substitute for contrast during the operation.

The patient required post-operative intubation because of ongoing hypoxia and required intensive care management with inotrope, colloid and plasma infusions.