Hospital Authority Convention 2008

- Patient safety issues and reporting: AIMS -

Hong Kong, May 2008

Bill Runciman

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The aim of science is not to open the door to everlasting wisdom, but to set a limit on everlasting error

Attributed to Galileo (1564-1642)
by Brecht (1898-1956)

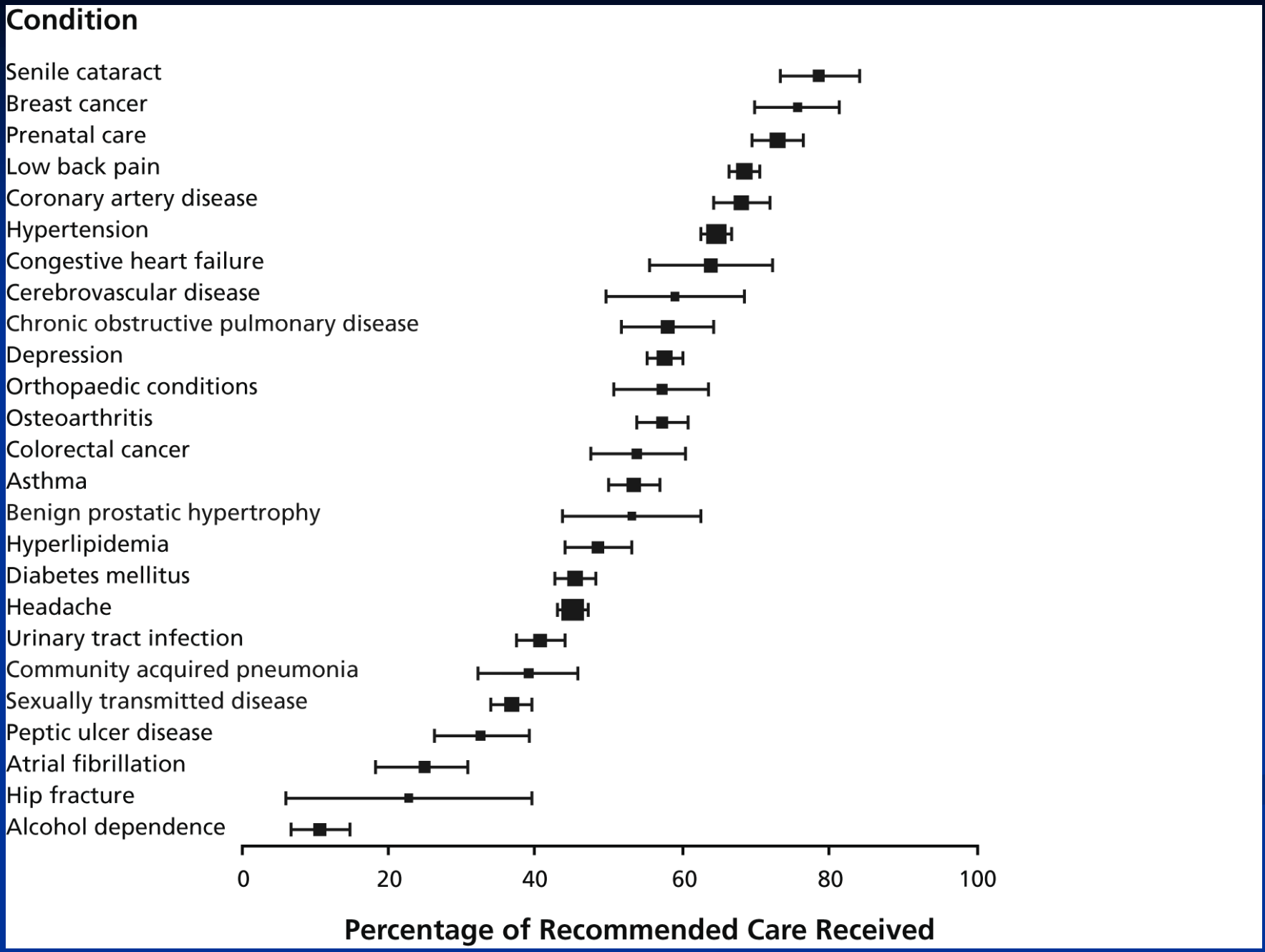
“the value of history lies in the fact that we learn by it from the mistakes of others…learning from our own is a slow process”

W. Stanley Sykes (1894-1961)

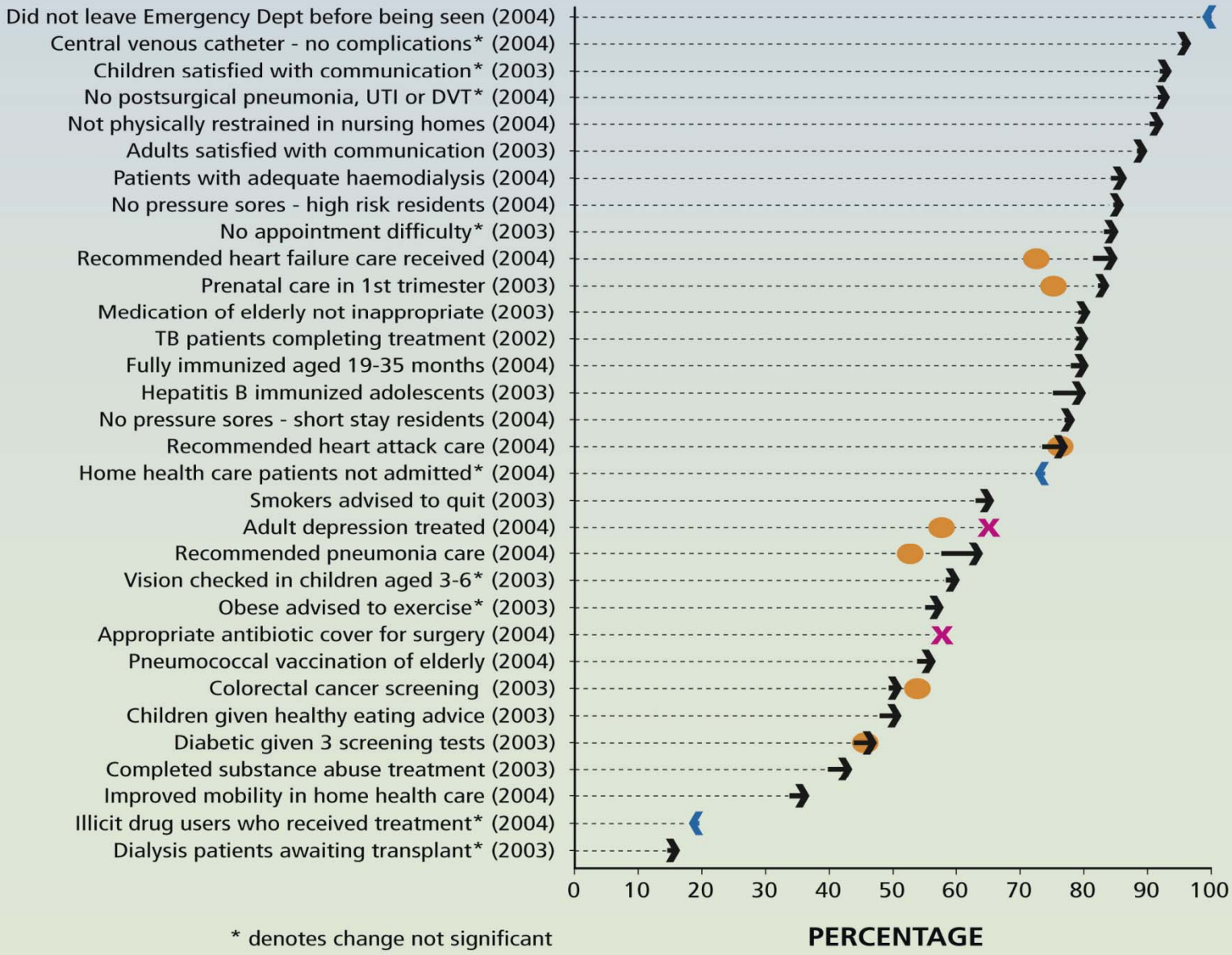
- Error -

- Making a flawed plan
- Flawed execution

Jim Reason


Condition
Senile cataract
Breast cancer
Prenatal care
Low back pain
Coronary artery disease
Hypertension
Congestive heart failure
Cerebrovascular disease
Chronic obstructive pulmonary disease
Depression
Orthopaedic conditions
Osteoarthritis
Colorectal cancer
Asthma
Benign prostatic hypertrophy
Hyperlipidemia
Diabetes mellitus
Headache
Urinary tract infection
Community acquired pneumonia
Sexually transmitted disease
Peptic ulcer disease
Atrial fibrillation
Hip fracture
Alcohol dependence
0
20
40
60
80
100
Percentage of Recommended Care Received

% OF ELIGIBLE PATIENTS WHO RECEIVED RECOMMENDED OR EXPECTED CARE



* denotes change not significant

Finding out about things that go wrong

- Retrospective
- Real-time
- Prospective

Retrospective

- Medical record review
- Administrative data
- Electronic records
- Reporting after the event
  - Incident monitoring
  - Complaint
  - Medicolegal files
  - Coroners' recommendations

Medical record review

- Poor inter-rater reliability
- Expensive and logistically difficult
- Most of "what" may be there
- "How" and "why" are not
- Misses 90% of types of event
- All studies show the same type of thing

Critical Incident Technique Flanagan - 1954

- "Essentially a procedure for gathering certain important facts concerning behaviour in defined situations"
- Requires "a classification system for any given type of critical incident"
- "Make inferences regarding practical procedures for improving performance based on the observed incidents"

Flanagan JC. The Critical Incident Technique. Psychological Bulletin, 1954; 51:327-358

Incident reporting

- 1,000 pupil pilots
- Combat veterans – combat leadership
- Research personnel
- Air traffic controllers

Flanagan JC. The Critical Incident Technique. Psychological Bulletin, 1954; 51:327-358

AIMS – Anaesthesia – 1988

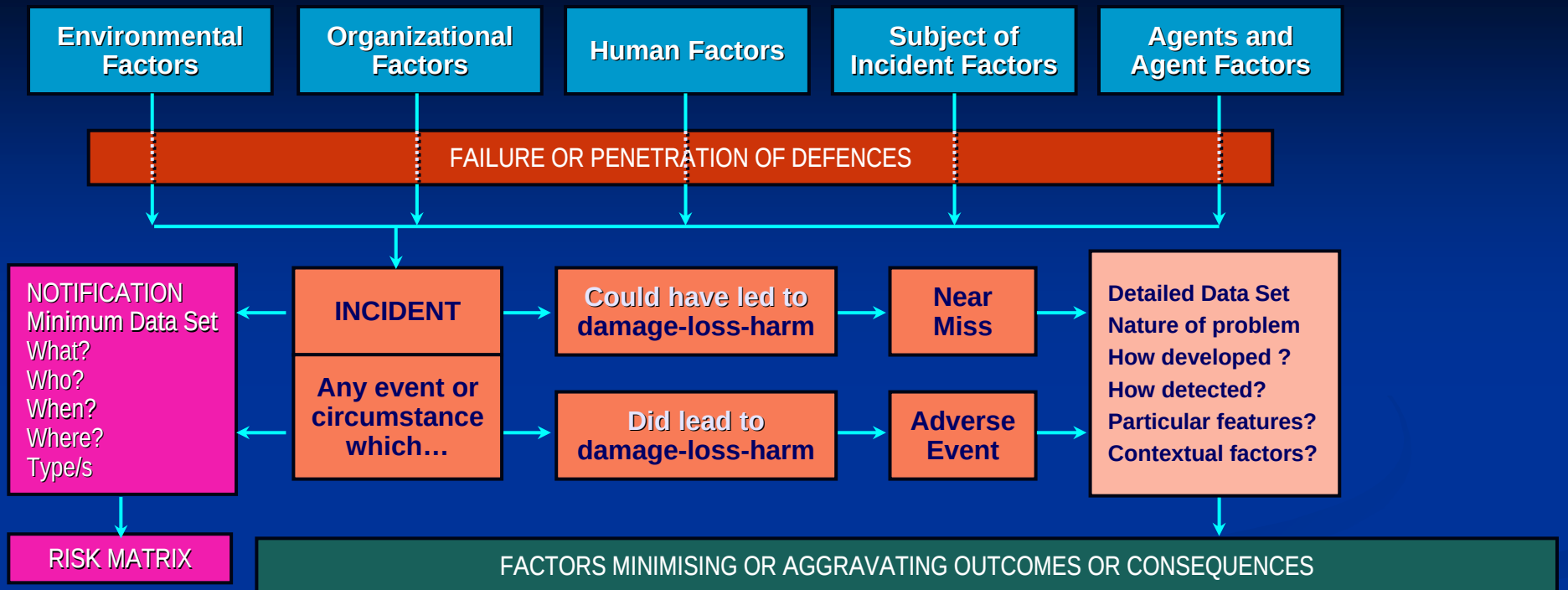
Symposium issue – Anaesthesia and Intensive Care, 1993

- 30 papers on errors, incidents and accidents in anaesthesia
- Applications and limitations of specific monitors
- Difficult intubation, anaphylaxis, cardiac arrest, pneumothorax – crisis management
- Incidents in recovery, regional anaesthesia, paediatrics, obstetrics, retrieval
- Equipment failure, system failure and human failure
- Over 100 recommendations - standards

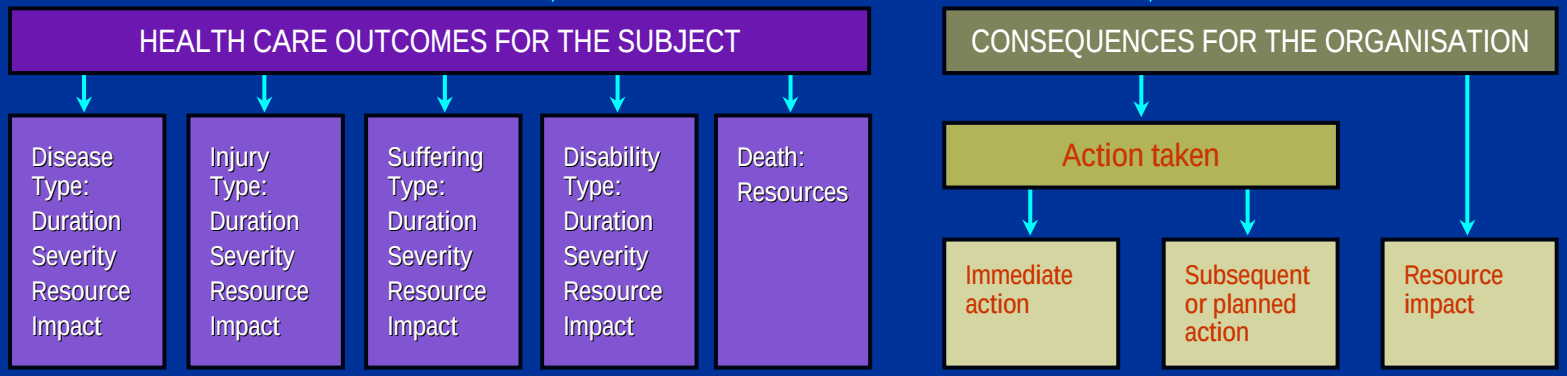
Generic AIMS

- 15 years experience (1993 onwards)
- Browser-based Version 4
- The Generic Occurrence Classification
- The Generic Reference Model
- The International Classification for Patient Safety – World Alliance for, WHO

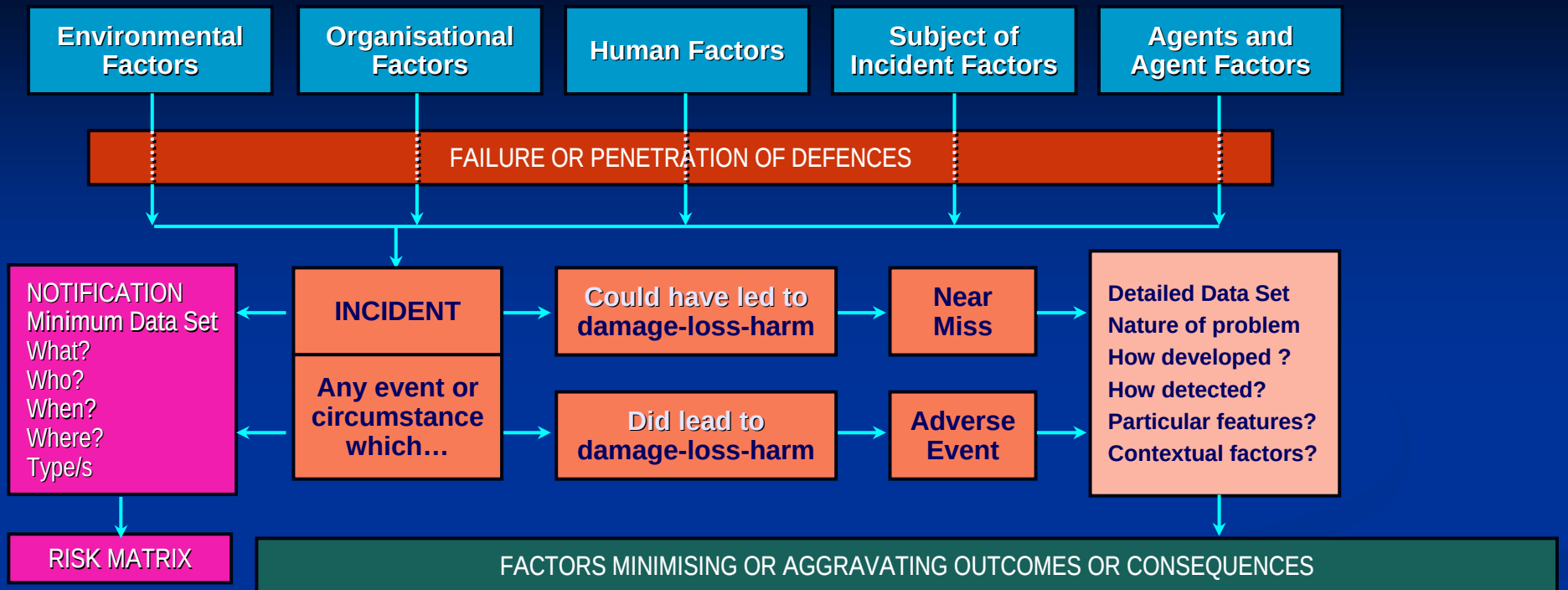
Contributing Factors and Hazards



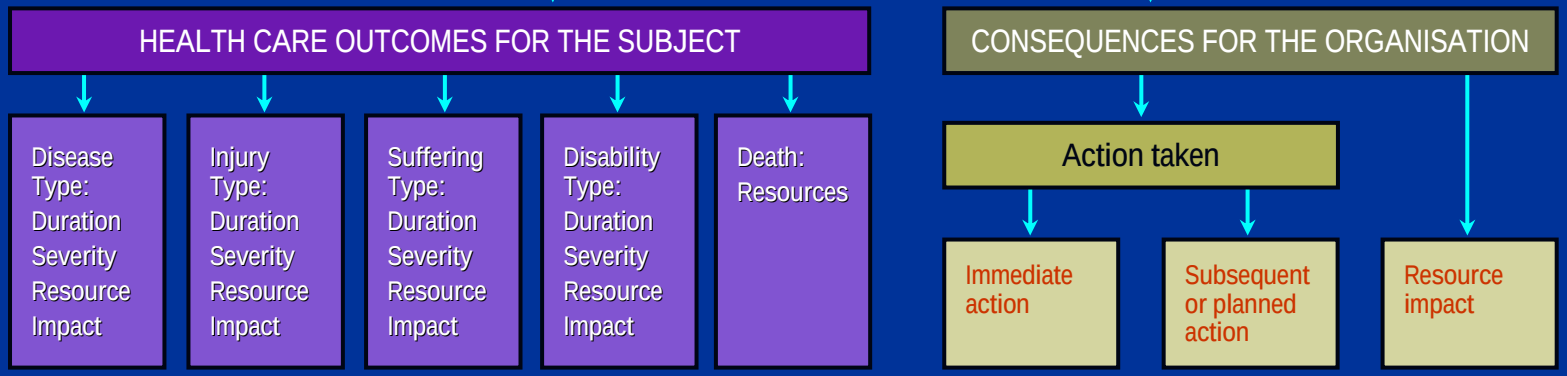
Outcomes & Consequences



Contributing Factors and Hazards



Outcomes & Consequences

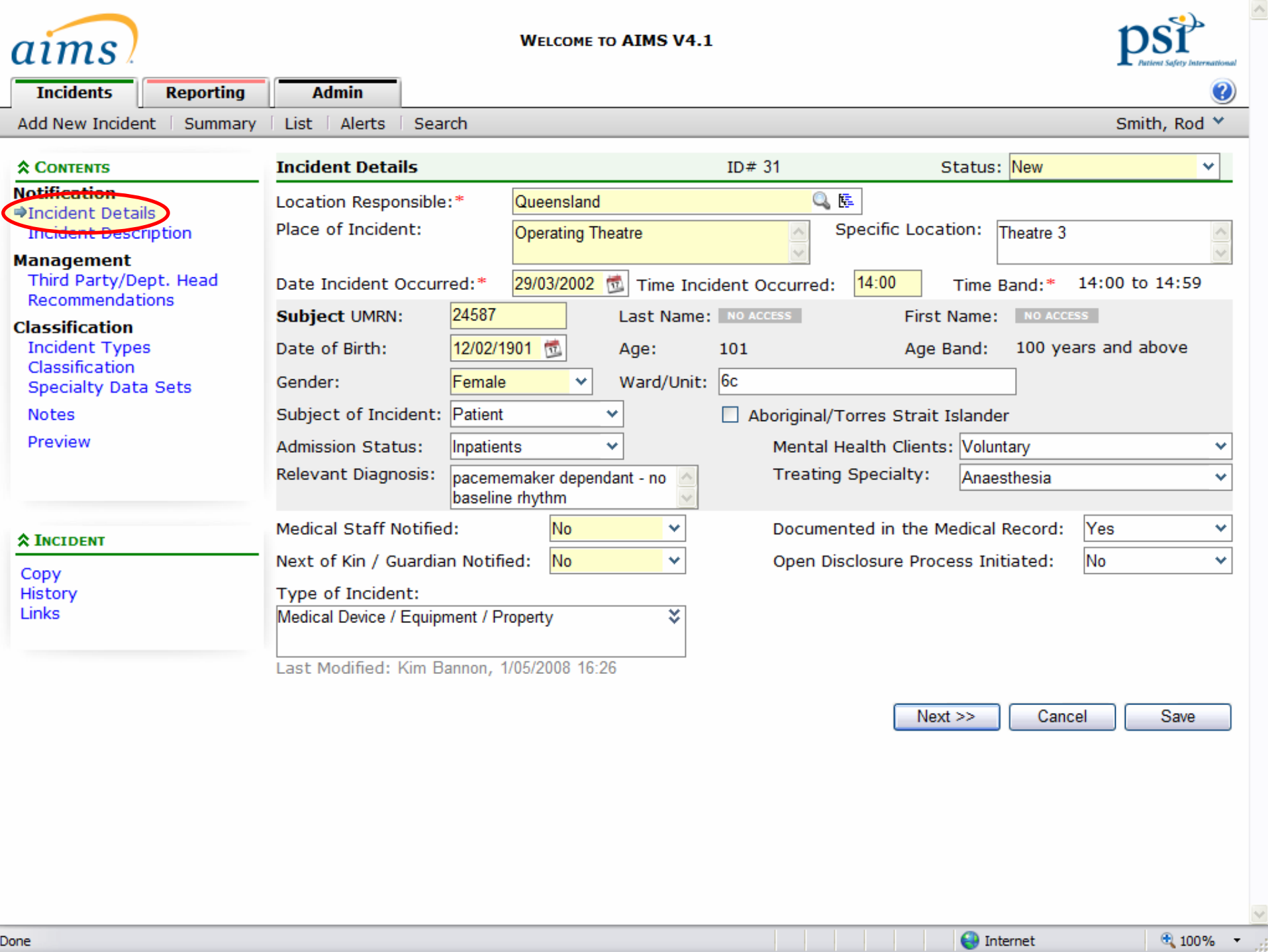


AIMS 4

- 60% of the population of Australia
- Over 100,000 users in New South Wales alone
- 10 surveys of over 2,500 users
- Improvements for Version 4
  - Training and software
  - Access
  - Analysis – complex queries
  - Benchmarking

AIMS 4

- Current developments
- National systems
- Call centres
- Eliciting information
- Point prevalence studies
- Specialty-based systems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ID# 31
Status: New
Location Responsible:*
Queensland
Place of Incident:
Operating Theatre
Specific Location:
Theatre 3
Date Incident Occurred:*
29/03/2002
Time Incident Occurred:
14:00
Time Band:*
14:00 to 14:59
Subject UMRN:
24587
Last Name:
NO ACCESS
First Name:
NO ACCESS
Date of Birth:
12/02/1901
Age:
101
Age Band:
100 years and above
Gender:
Female
Ward/Unit:
6c
Subject of Incident:
Patient
Aboriginal/Torres Strait Islander
Admission Status:
Inpatients
Mental Health Clients:
Voluntary
Relevant Diagnosis:
pacememaker dependant - no baseline rhythm
Treating Specialty:
Anaesthesia
Medical Staff Notified:
No
Documented in the Medical Record:
Yes
Next of Kin / Guardian Notified:
No
Open Disclosure Process Initiated:
No
Type of Incident:
Medical Device / Equipment / Property
Last Modified: Kim Bannon, 1/05/2008 16:26
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Incident Description

ID# 31 Status: New

Describe the actual or potential incident:*

95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion

Contributing Factors:*

The surgical technician should have checked equipment before use as per policy.

Treatment / Investigations Ordered:

No treatment necessary

What Factors Minimised the Outcome?

The fact that the patient was still in theatre monitored when the incident occurred.

How could the incident have been prevented?

Pre-implantation checking of the thesholds or the pacing device by the surgical technician.

Result of Incident: Near Miss

Level of Risk: Extreme (4)

1. Other Person Present: Scrub Nurse

2. Other Person Present: Surgeon

Reporter *(To submit the incident anonymously leave the following fields blank)*

First Name:	Last Name:	Contact Number:	Category:	Designation:
George	Bush	08 1234 5678	Doctor	Consultant

Last Modified: Rod Smith, 1/05/2008 17:32

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Third Party/Department Head

ID# 31 Status: New

Third Party

Third Party Comment #1

Pacemaker threshold is normally checked by technician the day before theatre as per policy. In future a technician will be present in theatre and check threshold immediately prior to implantation.

First Name:	Last Name:	Designation:	Date:	Time:
Tony	Blair	Biomedical Engineer	27/03/2002	11:00

Add Another Third Party Comment

Department/Service Head or Director

Comments

Incident referred to Biomedical Engineer - see above comment. Training to be arranged for next week's team meeting.

Impact on Organisation

This incident did not impact on the organisation this time, but could have had far reaching implications if it had not occurred in theatre.

Risk Evaluation: EXTREME 25

Further Investigation Required? Root Cause Analysis

Location Responsible: * Queensland

First Name:	Last Name:	Designation:	Date:	Time:
Jack	Smith	Department Head	28/03/2002	14:00

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Recommendations

ID# 31 Status: New

Recommendation #1

Recommendation: Training to be given to anaesthetists on how to test threshold.

Assigned To: Tom Jones

Assigned Area: Registrar

Comments: Training organised and conducted; all but 2 staff anaesthetists attended. Follow up training next week. Review success in 6 months time by analysis of AIMS data and training records.

Approved Date: 2/05/2002

Due Date: 14/05/2002

Review Date: 2/11/2002

Completed Date: 20/05/2002

Add Another Recommendation

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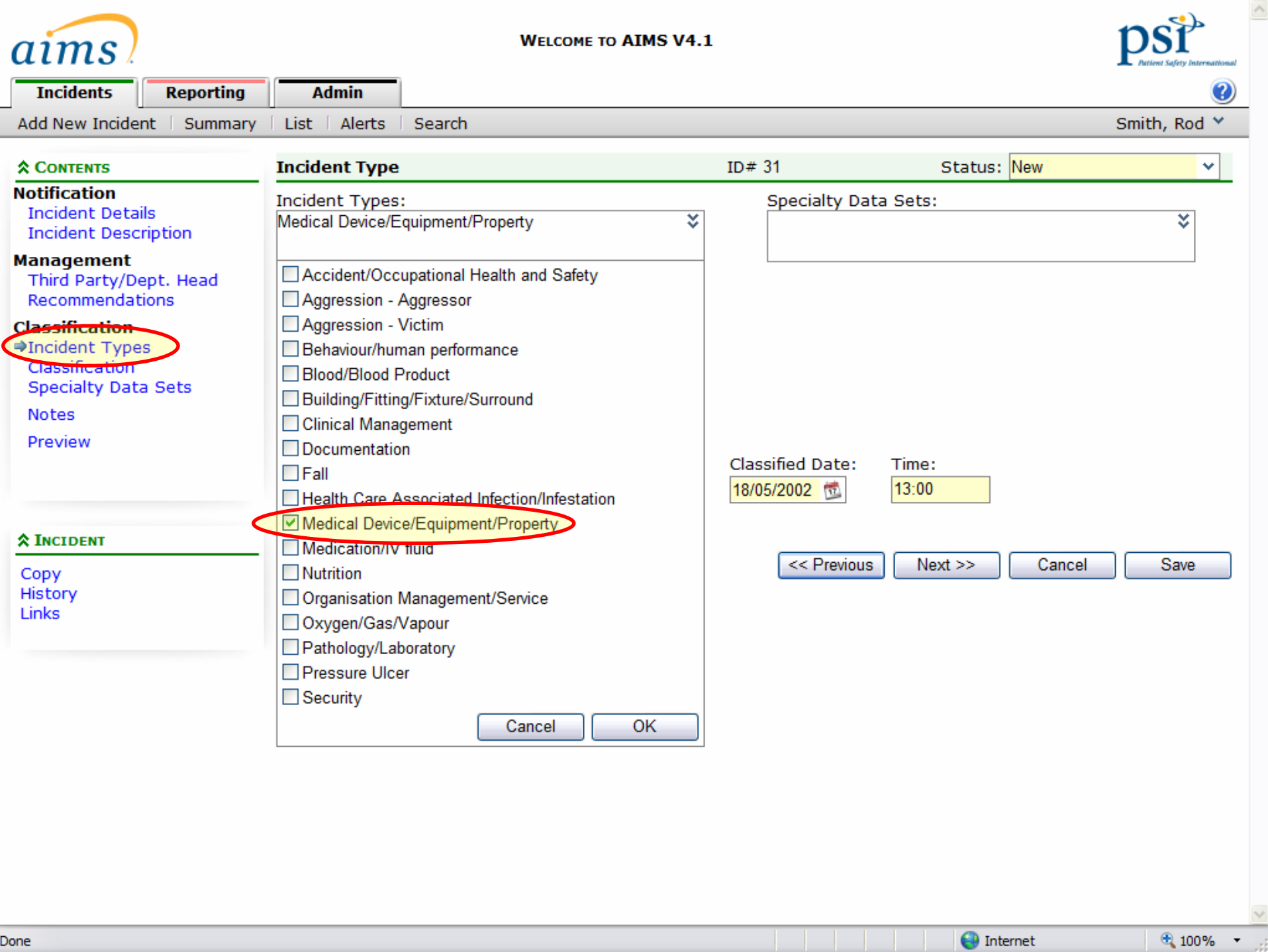
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Medical Device/Equipment/Property
Accident/Occupational Health and Safety
Aggression - Aggressor
Aggression - Victim
Behaviour/human performance
Blood/Blood Product
Building/Fitting/Fixture/Surround
Clinical Management
Documentation
Fall
Health Care Associated Infection/Infestation
Medical Device/Equipment/Property
Medication/IV fluid
Nutrition
Organisation Management/Service
Oxygen/Gas/Vapour
Pathology/Laboratory
Pressure Ulcer
Security
Cancel
OK
Specialty Data Sets:
Classified Date:
18/05/2002
Time:
13:00
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Incident Type ID# 31 Status: New

Incident Types:
Medical Device/Equipment/Property

Principal Incident Type:
Medical Device/Equipment/Property

Special Class Codes:

Active: ☑

Specialty Data Sets:
Anaesthesia

☑ Anaesthesia
☐ Obstetric - Foetal
☐ Obstetric - Maternal
Cancel OK

Classifier

First Name:	Last Name:	Classified Date:	Time:
Kim	Bannon	18/05/2002	13:00

Last Modified: Kim Bannon, 1/05/2008 18:31

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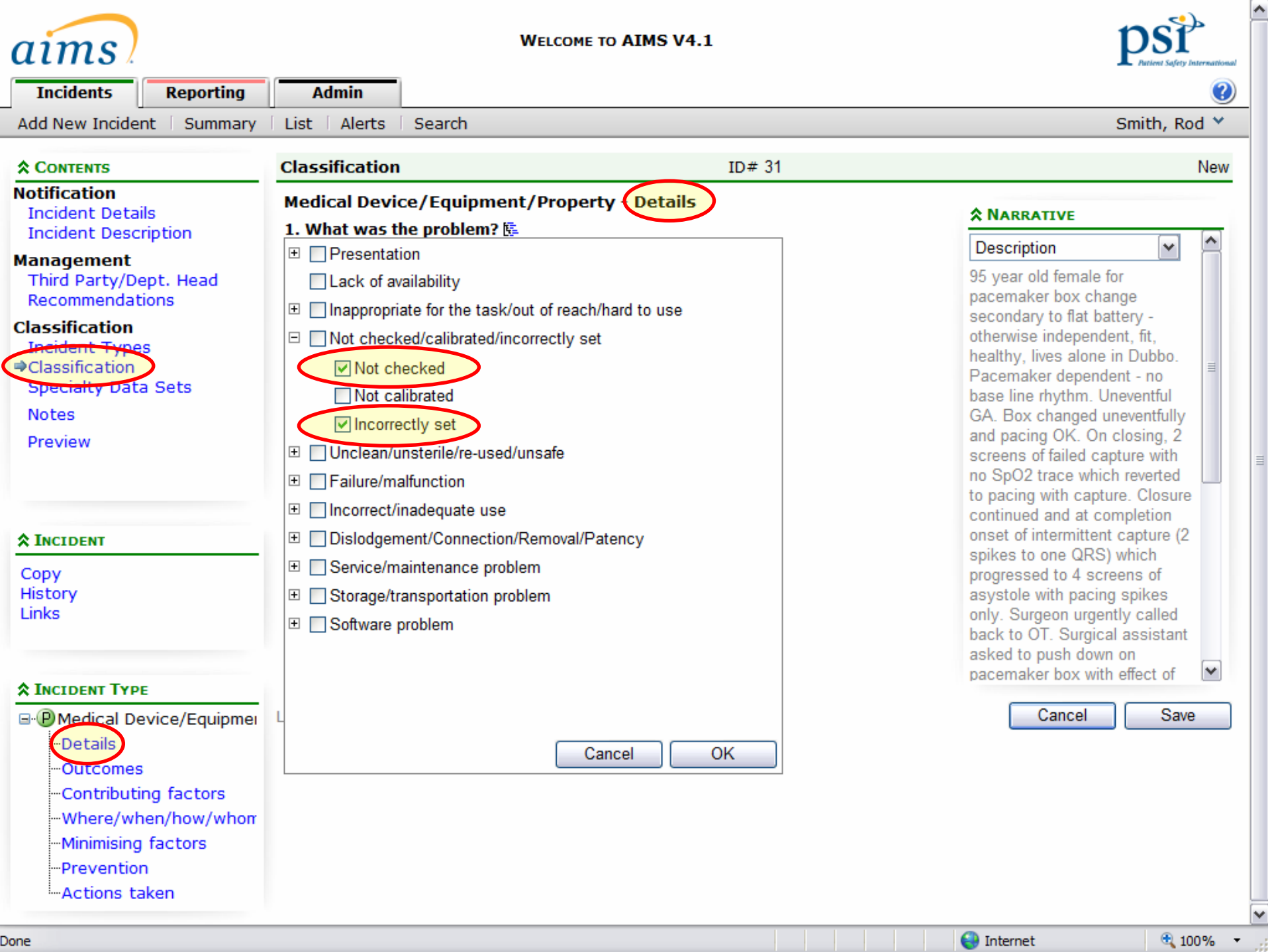
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Medical Device/Equipment/Property - Details
1. What was the problem?
Presentation
Lack of availability
Inappropriate for the task/out of reach/hard to use
Not checked/calibrated/incorrectly set
Not checked
Not calibrated
Incorrectly set
Unclean/unsterile/re-used/unsafe
Failure/malfunction
Incorrect/inadequate use
Dislodgement/Connection/Removal/Patency
Service/maintenance problem
Storage/transportation problem
Software problem
Cancel
OK
NARRATIVE
Description
95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of
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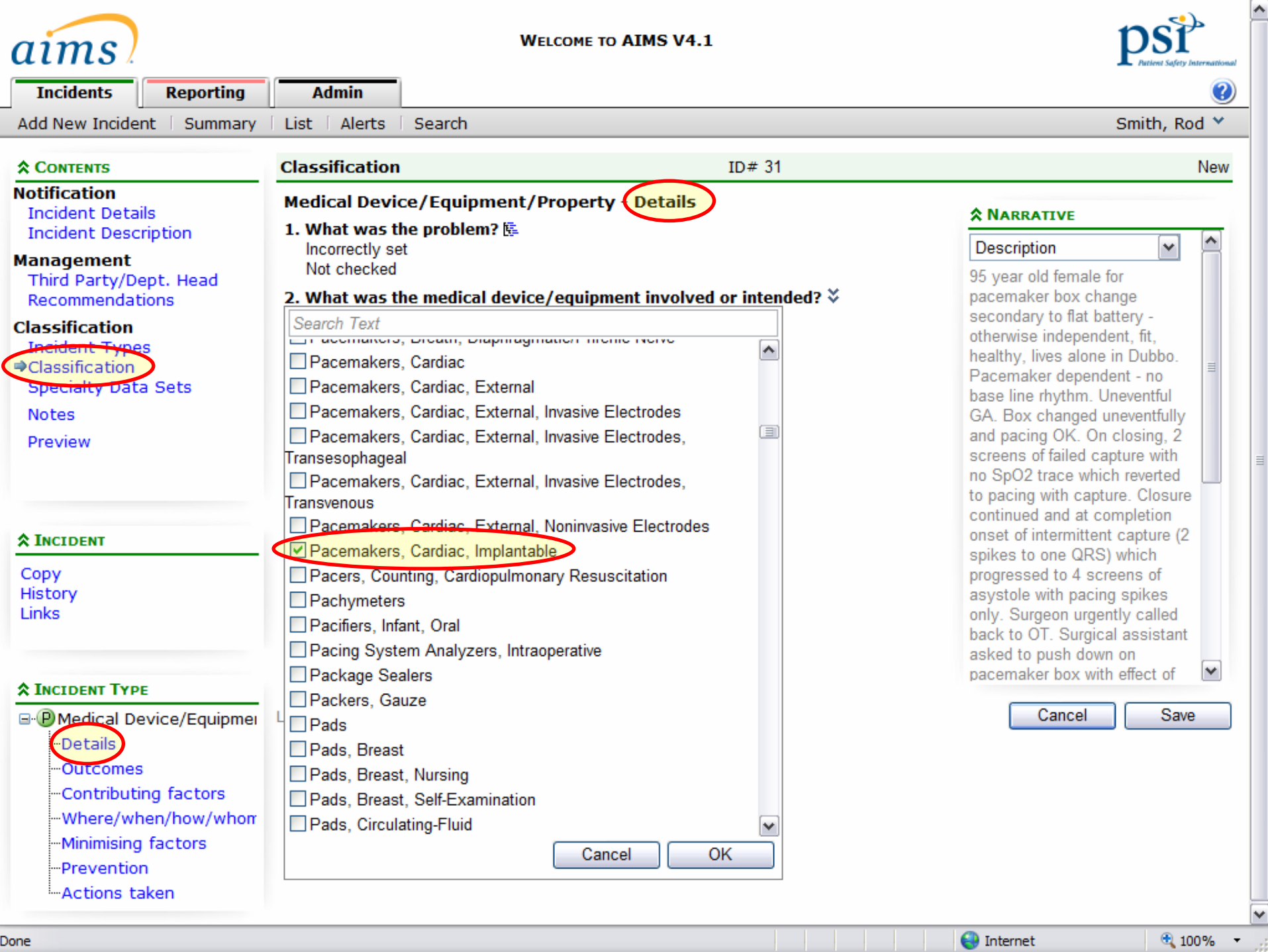
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Medical Device/Equipment/Property - Details
1. What was the problem?
Incorrectly set
Not checked
2. What was the medical device/equipment involved or intended?
Search Text
Pacemakers, Cardiac
Pacemakers, Cardiac, External
Pacemakers, Cardiac, External, Invasive Electrodes
Pacemakers, Cardiac, External, Invasive Electrodes, Transesophageal
Pacemakers, Cardiac, External, Invasive Electrodes, Transvenous
Pacemakers, Cardiac, External, Noninvasive Electrodes
Pacemakers, Cardiac, Implantable
Pacers, Counting, Cardiopulmonary Resuscitation
Pachymeters
Pacifiers, Infant, Oral
Pacing System Analyzers, Intraoperative
Package Sealers
Packers, Gauze
Pads
Pads, Breast
Pads, Breast, Nursing
Pads, Breast, Self-Examination
Pads, Circulating-Fluid
Cancel
OK
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Classification

ID# 31 — New

Medical Device/Equipment/Property - Outcomes

1. What impact did the incident have upon the organisation?

2. What was the outcome for the subject?

- [x] Nil
- [ ] Unknown/Not specified
- [ ] Patient absconded
- [ ] Procedural complication
- [ ] Pathophysiological/disease-related factors
- [ ] Injury
- [ ] Death

Cancel | OK

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Medical Device/Equipment/Property - Outcomes

1. What impact did the incident have upon the organisation?

2. What was the outcome for the subject?

Nil

3. What was the level of risk of severity of the outcome?

- Unknown
- Level 1
- Level 2
- **Level 3**
- Level 4
- Level 5
- Level 6
- Level 7
- Level 8

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Medical Device/Equipment/Property — Contributing factors

1. What were the identified contributing factors to the incident?

- [ ] Subject (human) factors
- [x] Staff (human) factors
- [ ] Other (human) factors
- [ ] Organisational Management/service factors
- [ ] Environmental/work area factors
- [ ] Document factors

Cancel | OK

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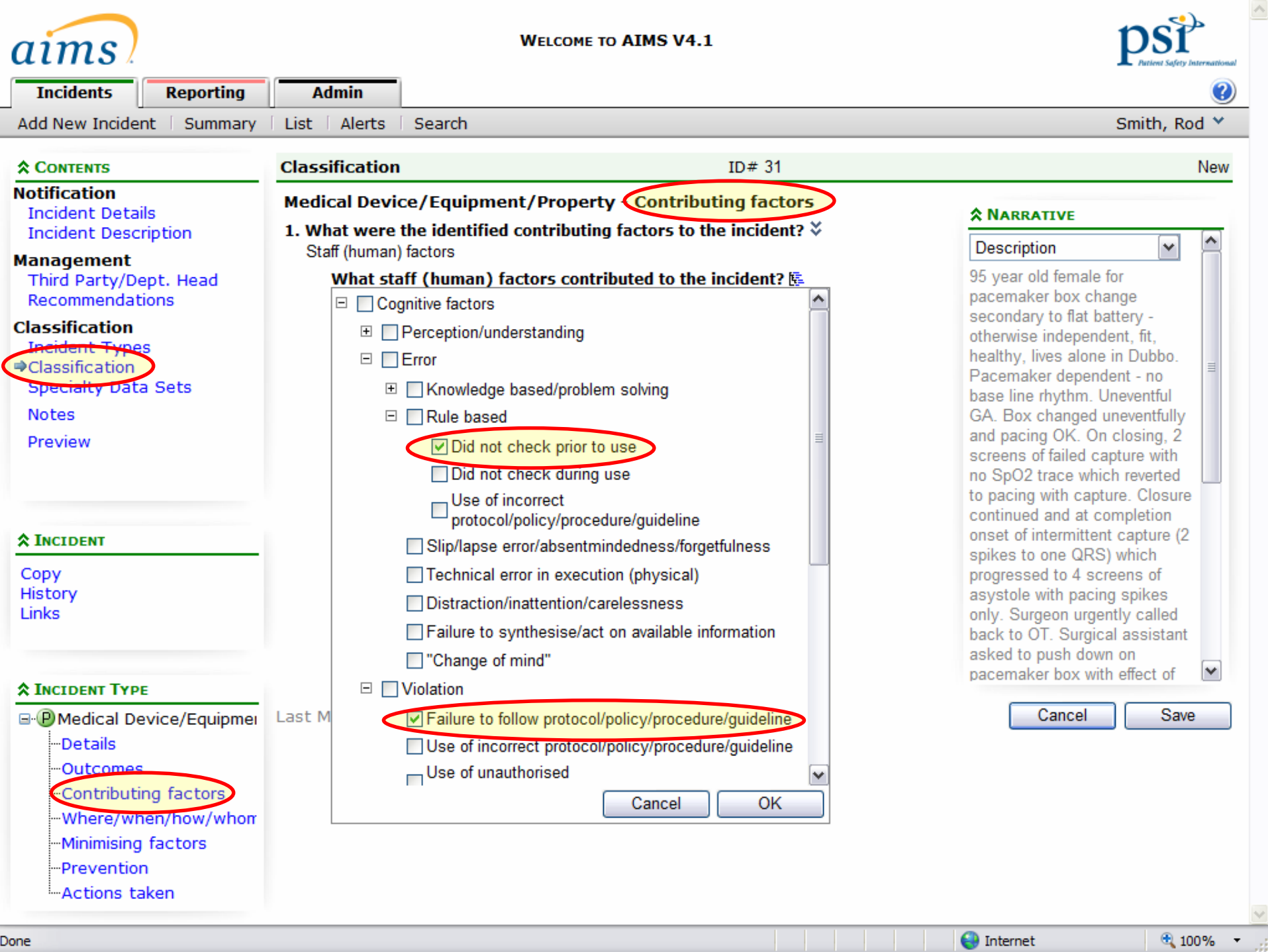
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Contributing factors
1. What were the identified contributing factors to the incident?
Staff (human) factors
What staff (human) factors contributed to the incident?
Cognitive factors
Perception/understanding
Error
Knowledge based/problem solving
Rule based
Did not check prior to use
Did not check during use
Use of incorrect protocol/policy/procedure/guideline
Slip/lapse error/absentmindedness/forgetfulness
Technical error in execution (physical)
Distraction/inattention/carelessness
Failure to synthesise/act on available information
"Change of mind"
Violation
Failure to follow protocol/policy/procedure/guideline
Use of incorrect protocol/policy/procedure/guideline
Use of unauthorised
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Medical Device/Equipment/Property — Where/when/how/whom

1. At what stage was the incident initiated?

- Before use
- During use
- After use

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Description

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Medical Device/Equipment/Property Where/when/how/whom

1. At what stage was the incident initiated?
During use

2. At what stage was the incident detected?

Before use
During use
After use

NARRATIVE

Description

95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of

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Classification

ID# 31 — New

Medical Device/Equipment/Property — Where/when/how/whom

1. At what stage was the incident initiated?
During use

2. At what stage was the incident detected?
During use

3. How was the incident detected?

- [ ] By noticing an error/fault
- [ ] By a change in the subject's condition
- [x] By a machine/system/environment change, or an alarm
- [ ] Missing/unlocatable object
- [ ] A count/audit/review

Cancel | OK

NARRATIVE

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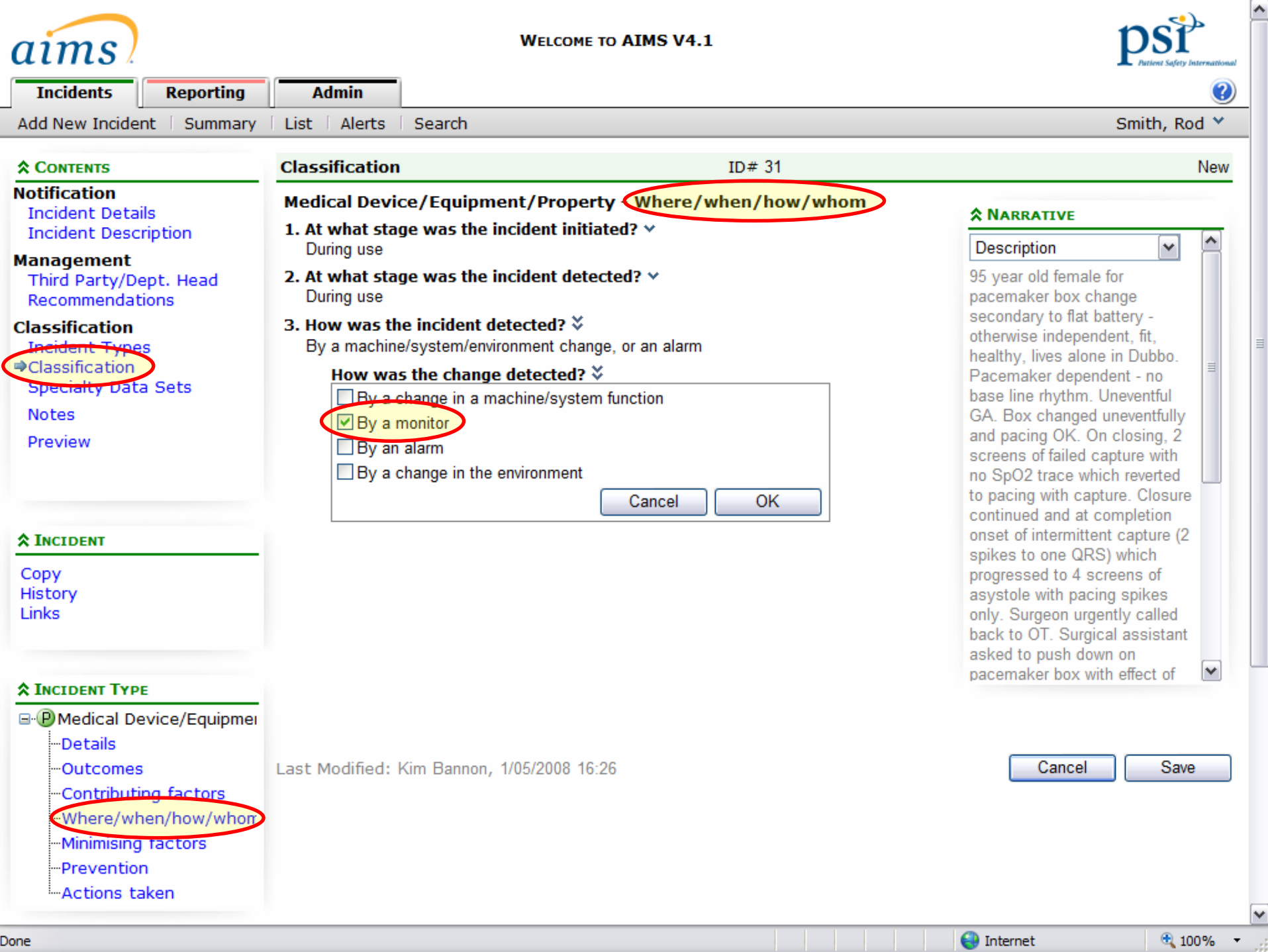
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Where/when/how/whom
1. At what stage was the incident initiated?
During use
2. At what stage was the incident detected?
During use
3. How was the incident detected?
By a machine/system/environment change, or an alarm
How was the change detected?
By a change in a machine/system function
By a monitor
By an alarm
By a change in the environment
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OK
NARRATIVE
Description
95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of
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Medical Device/Equipment/Property — **Where/when/how/whom**

1. At what stage was the incident initiated?
During use

2. At what stage was the incident detected?
During use

3. How was the incident detected?
By a machine/system/environment change, or an alarm

How was the change detected?
By a monitor

By whom, or what process?

- [ ] By the subject
- [ ] By the person directly responsible at the time
- [ ] By the person directly responsible later
- [x] By another person at the time
- [ ] By another person later
- [ ] By another department's checking process

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NARRATIVE

Description

95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of

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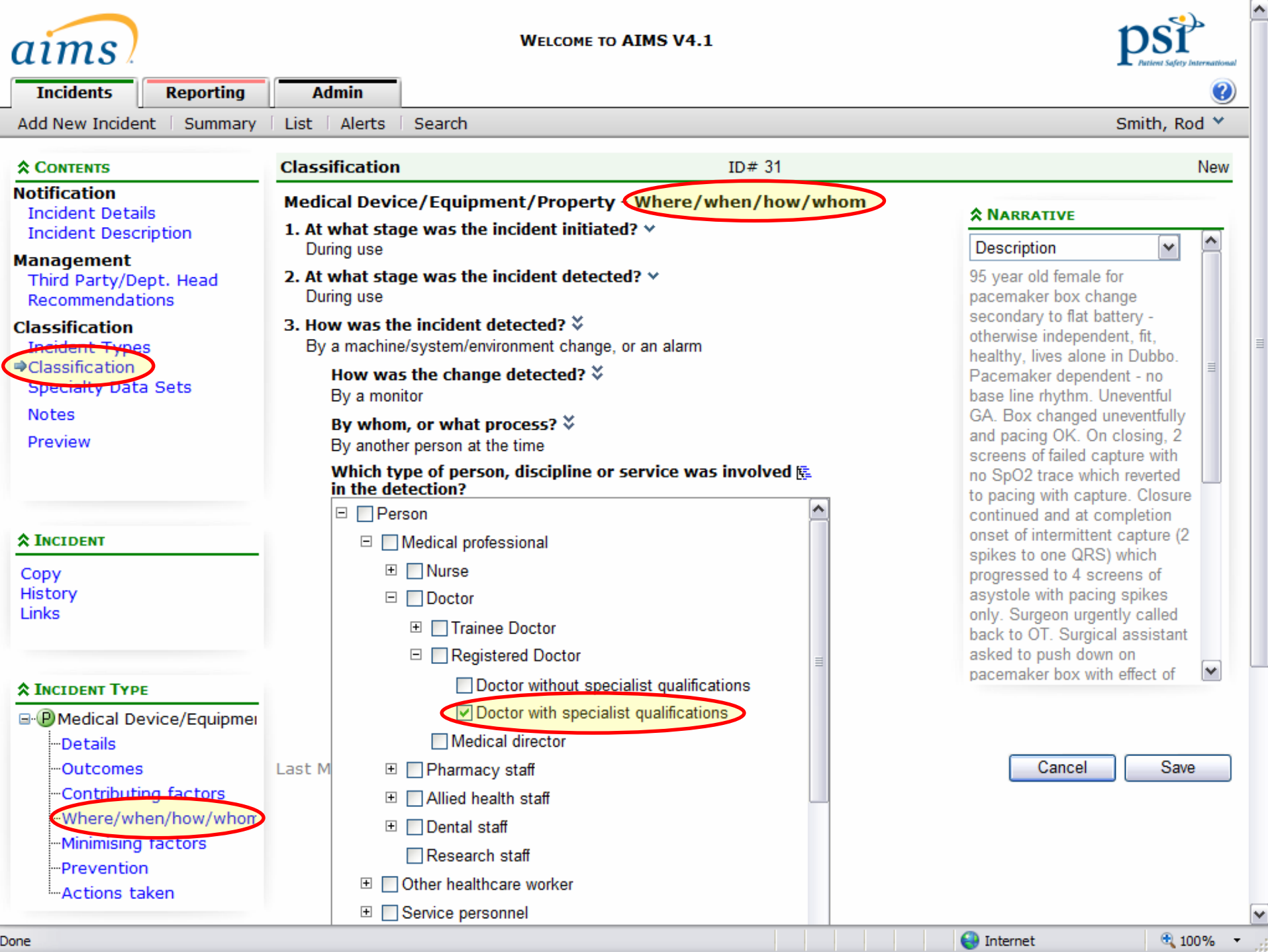
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Where/when/how/whom
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During use
2. At what stage was the incident detected?
During use
3. How was the incident detected?
By a machine/system/environment change, or an alarm
How was the change detected?
By a monitor
By whom, or what process?
By another person at the time
Which type of person, discipline or service was involved in the detection?
Person
Medical professional
Nurse
Doctor
Trainee Doctor
Registered Doctor
Doctor without specialist qualifications
Doctor with specialist qualifications
Medical director
Pharmacy staff
Allied health staff
Dental staff
Research staff
Other healthcare worker
Service personnel
Last M
NARRATIVE
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Medical Device/Equipment/Property — **Where/when/how/whom**

1. At what stage was the incident initiated?
During use

2. At what stage was the incident detected?
During use

3. How was the incident detected?
By a machine/system/environment change, or an alarm

How was the change detected?
By a monitor

By whom, or what process?
By another person at the time

Which type of person, discipline or service was involved in the detection?
Doctor with specialist qualifications

What is their employment status?

Clinical

Which discipline?

- [ ] Neonatology
- [ ] Paediatrics
- [x] Adult care
- [ ] Aged care/geriatrics
- [ ] General Practice/Primary Care/Community Service
- [ ] Alternative/adjunctive medicine

Last Modi

NARRATIVE

Description

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1. At what stage was the incident initiated?
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By a machine/system/environment change, or an alarm

How was the change detected?
By a monitor

By whom, or what process?
By another person at the time

Which type of person, discipline or service was involved in the detection?
Doctor with specialist qualifications

What is their employment status?

Clinical

Which discipline?
Adult care

Which discipline?

- [ ] Internal medicine service
- [ ] Surgery
- [ ] Emergency
- [ ] Acute care
  - [x] Anaesthesia service
    - [ ] Day of surgery admission clinic
    - [ ] Acute pain service
    - [ ] Chronic pain service
- [ ] Intensive/critical care service

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NARRATIVE

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3. How was the incident detected?
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How was the change detected?
By a monitor

By whom, or what process?
By another person at the time

Which type of person, discipline or service was involved in the detection?
Doctor with specialist qualifications

What is their employment status?

Clinical

Which discipline?
Adult care

Which discipline?
Anaesthesia service

4. What person, discipline or service was involved/responsible?

- [ ] Interpreter/translator
- [ ] Technical/Laboratory staff
  - [ ] Theatre technician
  - [ ] Radiographer
  - [ ] Biomedical engineer
  - [x] Biomedical technician
  - [ ] Maintenance/Engineering staff

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By a machine/system/environment change, or an alarm

How was the change detected?
By a monitor

By whom, or what process?
By another person at the time

Which type of person, discipline or service was involved in the detection?
Doctor with specialist qualifications

What is their employment status?

Clinical

Which discipline?
Adult care

Which discipline?
Anaesthesia service

4. What person, discipline or service was involved/responsible?
Biomedical technician

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Medical Device/Equipment/Property **Minimising factors**

1. What factors minimised the outcome of the incident?

- [ ] Actions or attributes of an individual
  - [ ] Early recognition
  - [x] Appropriate intervention by an individual
- [ ] Good supervision and good leadership
- [ ] Effective communication
- [ ] Good team work
- [ ] Use of equipment
  - [x] Monitor detection
  - [ ] Early warning by alarm
  - [ ] Well chosen equipment
  - [ ] Well positioned equipment
- [ ] Efficient safety mechanism(s) in place/use
- [ ] Effective protocol
- [ ] Query by another person (relative, visitor, etc)
- [ ] Good luck/chance

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NARRATIVE

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Medical Device/Equipment/Property — **Minimising factors**

1. What factors minimised the outcome of the incident?

Appropriate intervention by an individual

What was the intervention?

- [x] Quick response
- [ ] Timely first aid
- [ ] Previous experience
- [ ] Sought help
- [ ] Adherence to protocol
- [ ] Well trained for task
- [ ] Effective monitoring process
- [ ] Isolation of infected case

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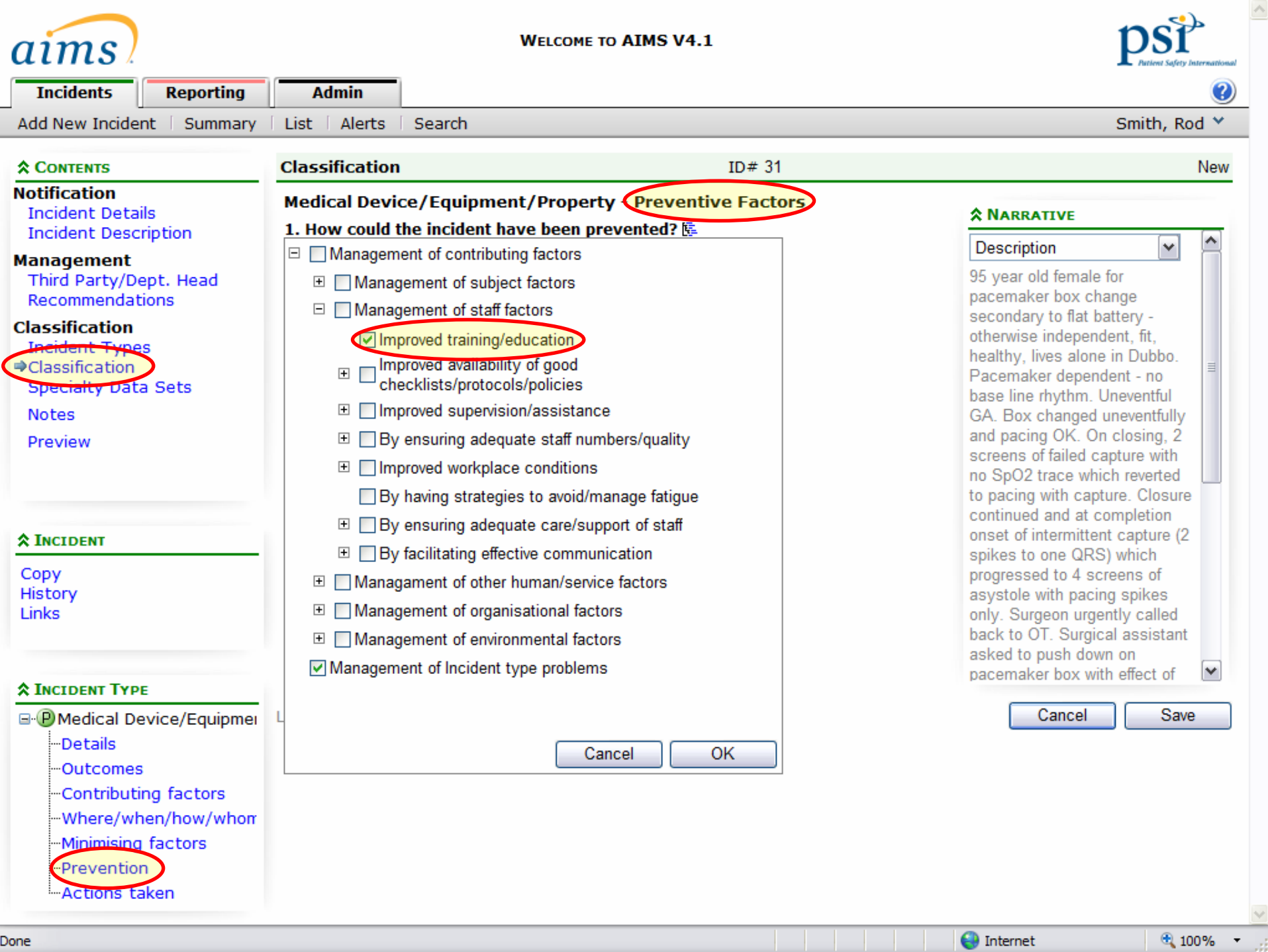
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Medical Device/Equipment/Property
Preventive Factors
1. How could the incident have been prevented?
Management of contributing factors
Management of subject factors
Management of staff factors
Improved training/education
Improved availability of good checklists/protocols/policies
Improved supervision/assistance
By ensuring adequate staff numbers/quality
Improved workplace conditions
By having strategies to avoid/manage fatigue
By ensuring adequate care/support of staff
By facilitating effective communication
Managament of other human/service factors
Management of organisational factors
Management of environmental factors
Management of Incident type problems
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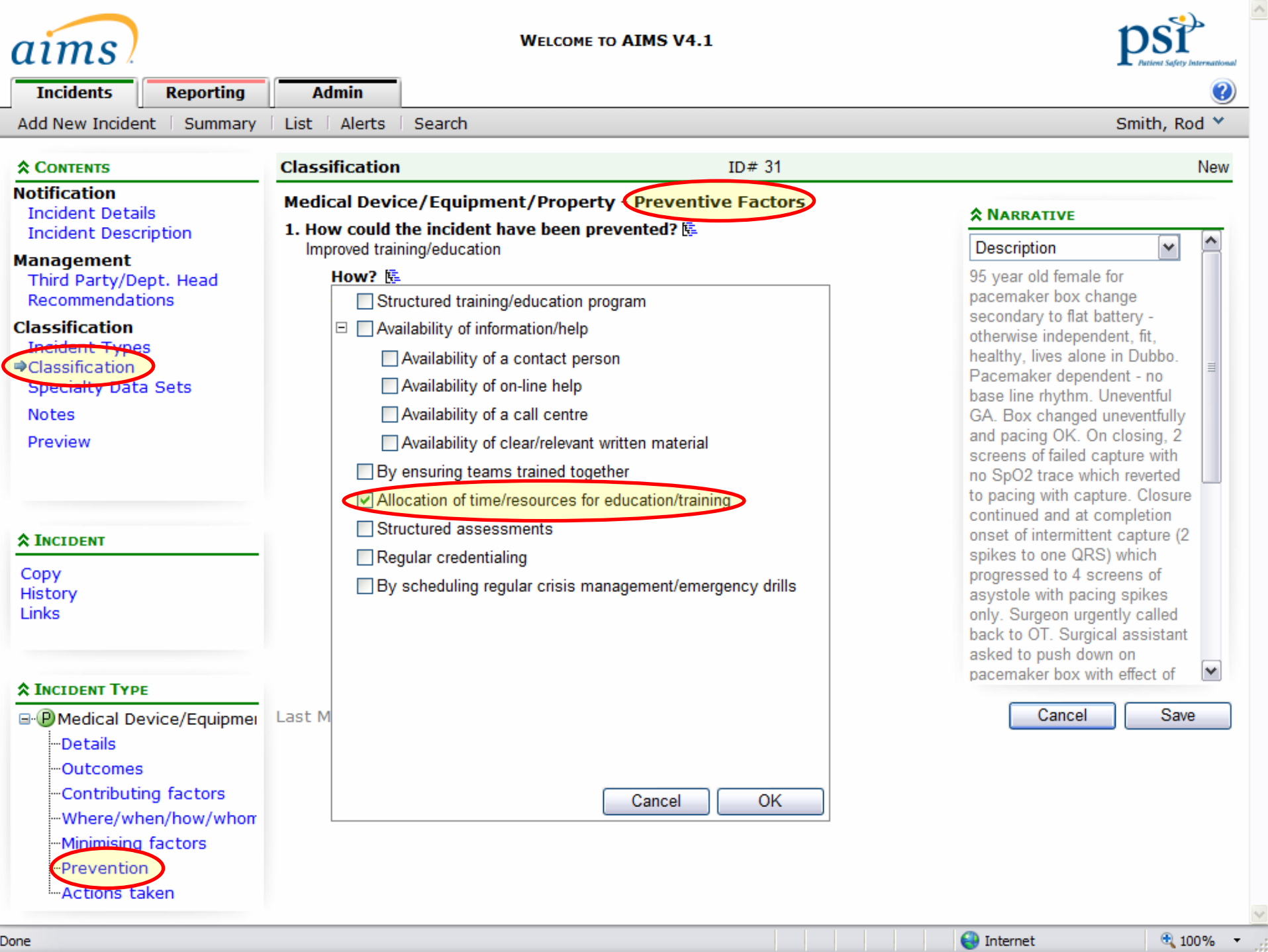
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Preventive Factors
1. How could the incident have been prevented?
Improved training/education
How?
Structured training/education program
Availability of information/help
Availability of a contact person
Availability of on-line help
Availability of a call centre
Availability of clear/relevant written material
By ensuring teams trained together
Allocation of time/resources for education/training
Structured assessments
Regular credentialing
By scheduling regular crisis management/emergency drills
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Medical Device/Equipment/Property — **Preventive Factors**

1. How could the incident have been prevented?

Improved training/education

How?

Allocation of time/resources for education/training

Management of Incident type problems

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Medical Device/Equipment/Property — **Actions taken**

1. What actions were taken to manage the incident?

- [x] Short term actions/strategies
- [ ] Long term actions/strategies

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NARRATIVE

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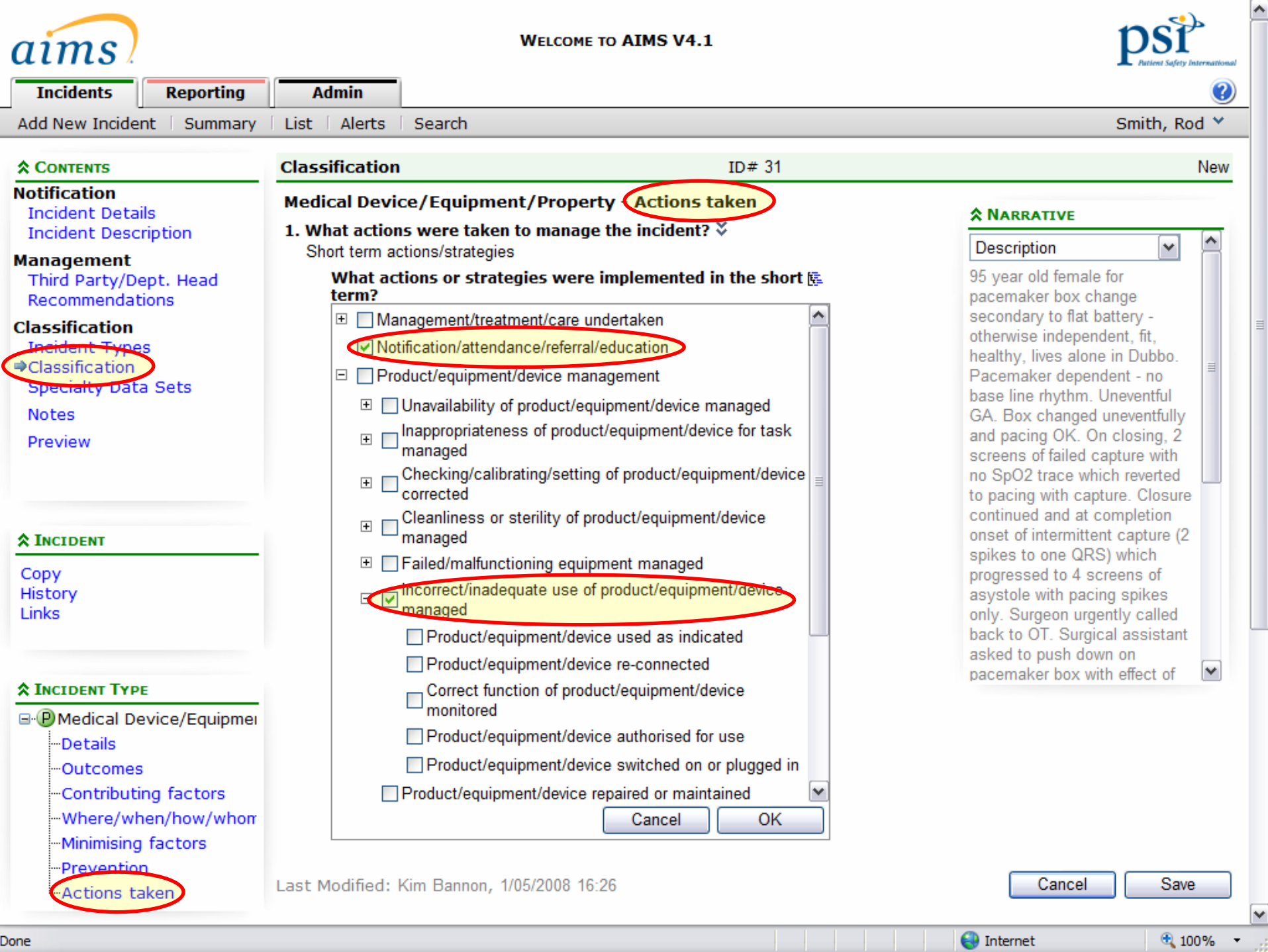
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Actions taken
1. What actions were taken to manage the incident?
Short term actions/strategies
What actions or strategies were implemented in the short term?
Management/treatment/care undertaken
Notification/attendance/referral/education
Product/equipment/device management
Unavailability of product/equipment/device managed
Inappropriateness of product/equipment/device for task managed
Checking/calibrating/setting of product/equipment/device corrected
Cleanliness or sterility of product/equipment/device managed
Failed/malfunctioning equipment managed
Incorrect/inadequate use of product/equipment/device managed
Product/equipment/device used as indicated
Product/equipment/device re-connected
Correct function of product/equipment/device monitored
Product/equipment/device authorised for use
Product/equipment/device switched on or plugged in
Product/equipment/device repaired or maintained
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OK
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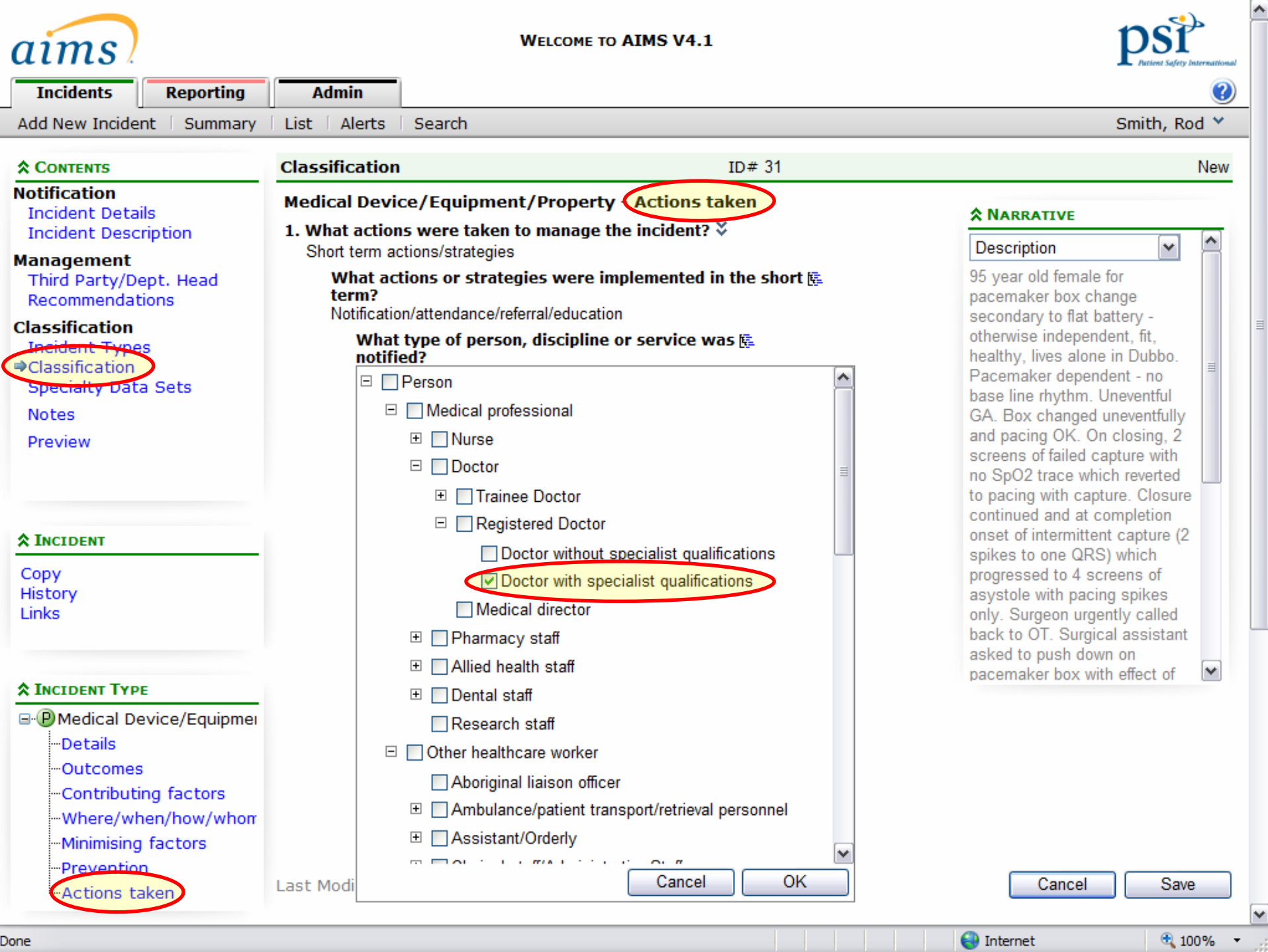
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Short term actions/strategies
What actions or strategies were implemented in the short term?
Notification/attendance/referral/education
What type of person, discipline or service was notified?
Person
Medical professional
Nurse
Doctor
Trainee Doctor
Registered Doctor
Doctor without specialist qualifications
Doctor with specialist qualifications
Medical director
Pharmacy staff
Allied health staff
Dental staff
Research staff
Other healthcare worker
Aboriginal liaison officer
Ambulance/patient transport/retrieval personnel
Assistant/Orderly
Cancel
OK
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Classification ID# 31 New

Medical Device/Equipment/Property **Actions taken**

1. What actions were taken to manage the incident?

Short term actions/strategies

What actions or strategies were implemented in the short term?

Notification/attendance/referral/education

What type of person, discipline or service was notified?

Doctor with specialist qualifications

What is their employment status?

Biomedical technician

Clinical

Which discipline?

- [ ] Neonatology
- [ ] Paediatrics
- [x] Adult care
- [ ] Aged care/geriatrics
- [ ] General Practice/Primary Care/Community Service
- [ ] Alternative/adjunctive medicine

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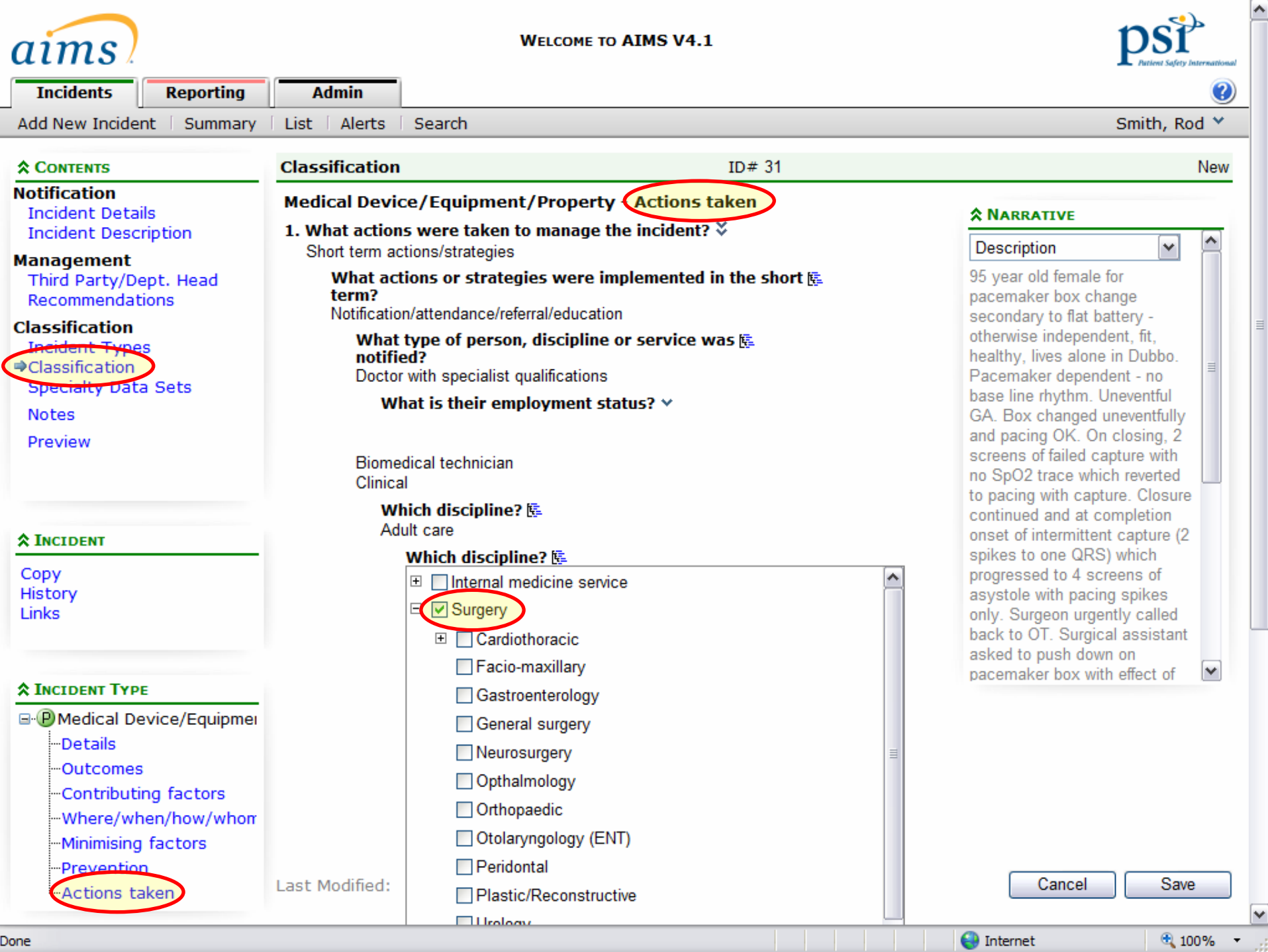
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Notification/attendance/referral/education
What type of person, discipline or service was notified?
Doctor with specialist qualifications
What is their employment status?
Biomedical technician
Clinical
Which discipline?
Adult care
Which discipline?
Internal medicine service
Surgery
Cardiothoracic
Facio-maxillary
Gastroenterology
General surgery
Neurosurgery
Opthalmology
Orthopaedic
Otolaryngology (ENT)
Peridontal
Plastic/Reconstructive
Urology
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Description
95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of
Cancel
Save
Done
Internet
100%

Classification

ID# 31 New

Medical Device/Equipment/Property **Actions taken**

1. What actions were taken to manage the incident?

Short term actions/strategies

What actions or strategies were implemented in the short term?

Notification/attendance/referral/education

What type of person, discipline or service was notified?

Doctor with specialist qualifications

What is their employment status?

Biomedical technician

Clinical

Which discipline?

Adult care

Which discipline?

Surgery

What type of person, discipline or service attended?

Doctor with specialist qualifications

What is their employment status?

Biomedical technician

What type of person, discipline or service was the subject referred to?

Who was educated/debriefed/counselled/reassured?

Incorrect/inadequate use of product/equipment/device managed

Last Modified: Rod Smith , 1/05/2008 17:33

Cancel Save

NARRATIVE

Description

95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of

Specialty Data Set ID# 31 New

Anaesthesia - Details

1. Had the subject had previous anaesthesia?

Yes
No

ia?

NARRATIVE

Description

95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of

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SPECIALTY DATA SETS
Anaesthesia
Details
Where/when/how/whom

Specialty Data Set ID# 31 New

Anaesthesia - Details

1. Had the subject had previous anaesthesia?
Yes

Had the subject had complications from past anaesthesia?

2. What were the subject's identified risk factors?

- [ ] Potentially difficult airway
- [ ] Risk of aspiration
- [ ] Respiratory risks
- [x] Cardiovascular risks
  - [ ] Ischaemic heart disease/angina
  - [ ] Hypertension
  - [ ] Valvular heart disease
  - [ ] Hypovolaemia/postural hypotension
- [ ] Metabolic risks
- [ ] Infections
- [ ] Medication risks
- [x] Age factor
- [ ] Pregnancy
- [ ] Recent major surgery
- [ ] Relevant family history
- [ ] Difficult IV access

Cancel OK

NARRATIVE

Description

95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of

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SPECIALTY DATA SETS
Anaesthesia
Details
Where/when/how/whom

Specialty Data Set ID# 31 New

Anaesthesia - Details

1. Had the subject had previous anaesthesia?
Yes

Had the subject had complications from past anaesthesia?

2. What were the subject's identified risk factors?
Cardiovascular risks
Age factor

3. What was the estimated ASA risk status?
ASA 3

4. Was this an elective, an urgent or an emergency procedure?
Elective procedure

5. What was the anaesthetic technique in use at the time?
IPPV with single lumen endotracheal tube

6. What monitoring was in use when the incident occurred?

- [x] Oxygen analyser monitor/alarm
- [ ] Nitrous oxide monitor/alarm
- [x] Volatile agent monitor/alarm
- [x] Gas flow/Spirometer
- [ ] Gas circuit/patient airway temperature monitor
- [ ] Circuit monitor/alarm
  - [x] High pressure alarm
  - [x] Pressure gauge
  - [ ] Low pressure (apnoea) alarm
  - [x] Other extubation/circuit disconnection alarm
- [ ] Patient monitoring
  - [x] Pulse oximeter
  - [ ] Auscultation

NARRATIVE

Description

95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of

Cancel Save

Specialty Data Set ID# 31 New

Anaesthesia - Where/when/how/whom

1. At what stage in the anaesthesia process did the problem occur?

Pre-admission
Pre-anaesthetic clinic
Pre-operative visit to patient
Pre-operative ward preparation
During transport to the procedure location
During in-theatre preparation
Pre-induction
During induction
During maintenance of anaesthesia
During reversal
During emergence
During transport from the procedure location
During recovery
Following discharge from recovery

NARRATIVE

Description

95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of

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Incident Preview

ID# 31 New

Notification

ID: 31
Location Responsible: Queensland
Place of Incident: Operating Theatre
Specific Location: Theatre 3
Date/Time: 29/03/2002 14:00
Subject of Incident: Patient
Aboriginal/Torres Strait Islander: No

Subject: NO ACCESS NO ACCESS
UMRN: 24587
Age: 101
Gender: Female
Ward/Unit: 6c
Mental Health Clients: Voluntary
Admission Status: Inpatients

Relevant Diagnosis: pacememaker dependant - no baseline rhythm

Treating Specialty: Anaesthesia

Medical Staff Notified: No
Next of Kin / Guardian Notified: No

Documented in the Medical Record: Yes
Open Disclosure Process Initiated: No

Type of Incident:
Medical Device / Equipment / Property

Edit

Incident Description:
95 year old female for pacemaker box change secondary to flat battery - otherwise independent, fit, healthy, lives alone in Dubbo. Pacemaker dependent - no base line rhythm. Uneventful GA. Box changed uneventfully and pacing OK. On closing, 2 screens of failed capture with no SpO2 trace which reverted to pacing with capture. Closure continued and at completion onset of intermittent capture (2 spikes to one QRS) which progressed to 4 screens of asystole with pacing spikes only. Surgeon urgently called back to OT. Surgical assistant asked to push down on pacemaker box with effect of re-establishing capture. The lead threshold had not been tested. This was then down and the threshold increased to ensure adequate capture. Thought by surgeon to be due to air in the pacemaker boc packet interfering with contact (unipolar lead). Fortunately this occurred in OT with full monitoring. Lucky it didn't happen on T/F to Recovery etc.

Contributing Factors:
The surgical technician should have checked equipment before use as per policy.

Treatment / Investigations Ordered:
No treatment necessary

What Factors Minimised the Outcome?
The fact that the patient was still in theatre monitored when the incident occurred.

How could the incident have been prevented?
Pre-implantation checking of the thesholds or the pacing device by the surgical technician.

Pre-implantation checking of the thesholds or the pacing device by the surgical technician.

Result of Incident: Near Miss
Level of Risk: Extreme (4)
1. Other Person Present: Scrub Nurse
2. Other Person Present: Surgeon
Reporter: George Bush Consultant
Contact No.: 08 1234 5678

Edit

Management

Third Party

Third Party Comment #1:
Pacemaker threshold is normally checked by technician the day before theatre as per policy. In future a technician will be present in theatre and check threshold immediately prior to implantation. Surgeons given instructions/training on how to test threshold if there is no surgical technician available.

Third Party Name:
Tony Blair
Comment Date/Time:
27/03/2002 11:00

Department Head

Comments:
Incident referred to Biomedical Engineer - see above comment. Training to be arranged for next week's team meeting.
Impact on Organisation:
This incident did not impact on the organisation this time, but could have had far reaching implications if it had not occurred in theatre.

Preview

Risk Evaluation:
EXTREME 25 (Catastrophic, Almost Certain)
Further Investigation Required:
Root Cause Analysis
Department Head Name:
Jack Smith Department Head
Comment Date/Time:
28/03/2002 14:00

Edit

Recommendations

Recommendation #1
Recommendation:
Training to be given to anaesthetists on how to test threshold.
Assigned To: Tom Jones
Assigned Area: Registrar
Comments:
Training organised and conducted; all but 2 staff anaesthetists attended. Follow up training next week. Review success in 6 months time by analysis of AIMS data and training records.
Approved Date: 2/05/2002
Due Date: 14/05/2002
Review Date: 2/11/2002
Completed Date: 20/05/2002

Edit

Classification

Incident Types:
Medical Device/Equipment/Property
Principal Incident Type: Medical Device/Equipment/Property
Specialty Data Sets: Anaesthesia

Principal Incident Type: Medical Device/Equipment/Property
Specialty Data Sets: Anaesthesia
Special Class Codes:
Classifier: Kim Bannon **Classified Date/Time:** 18/05/2002 13:00

Edit

Medical Device/Equipment/Property

Details

What was the problem?

Incorrectly set

Not checked

What was the medical device/equipment involved or intended?

Pacemakers, Cardiac, Implantable

Edit

Outcomes

What was the outcome for the subject?

Nil

What was the level of risk of severity of the outcome?

Level 3

Preview

Edit

Contributing factors

What staff (human) factors contributed to the incident

Did not check prior to use

Failure to follow protocol/policy/procedure/guideline

Edit

Where/when/how/whom

At what stage was the incident initiated?

During use

At what stage was the incident detected?

During use

How was the incident detected?

By a machine/system/environment change, or an alarm

How was the change detected?

By a monitor

By whom, or what process?

By another person at the time

Which type of person, discipline or service was involved in the detection?

Doctor with specialist qualifications

Doctor with specialist qualifications
Clinical
Which discipline?
Adult care
Which discipline?
Anaesthesia service
What person, discipline or service was involved/responsible?
Biomedical technician

Edit

Minimising factors

What factors minimised the outcome of the incident?
Appropriate intervention by an individual
What was the intervention?
Quick response
Monitor detection

Edit

Prevention

Preview

How could the incident have been prevented?
Improved training/education
How?
Allocation of time/resources for education/training
Management of Incident type problems

Edit

Actions taken

What actions or strategies were implemented in the short term?
Notification/attendance/referral/education
What type of person, discipline or service was notified?
Clinical
Which discipline?
Adult care
Which discipline?
Surgery
Biomedical technician
Doctor with specialist qualifications
What type of person, discipline or service attended?
Doctor with specialist qualifications
Biomedical technician

Biomedical technician

Incorrect/inadequate use of product/equipment/device managed

Edit

Anaesthesia

Details

Had the subject had previous anaesthesia?

Yes

What were the subject's identified risk factors?

Age factor

Cardiovascular risks

What was the estimated ASA risk status?

ASA 3

Was this an elective, an urgent or an emergency procedure?

Elective procedure

What was the anaesthetic technique in use at the time?

IPPV with single lumen endotracheal tube

What monitoring was in use when the incident occurred?

Pressure gauge

Volatile agent monitor/alarm

Heart (pulse) rate monitor

High pressure alarm

Gas flow/Spirometer

Pulse oximeter

Other extubation/circuit disconnection alarm

Oxygen analyser monitor/alarm

Electrocardiogram (ECG)

Peripheral nerve stimulator

Automatic sphygmomanometer

Capnograph

Edit

Where/when/how/whom

At what stage in the anaesthesia process did the problem occur?

During maintenance of anaesthesia

Edit

Notes

Edit

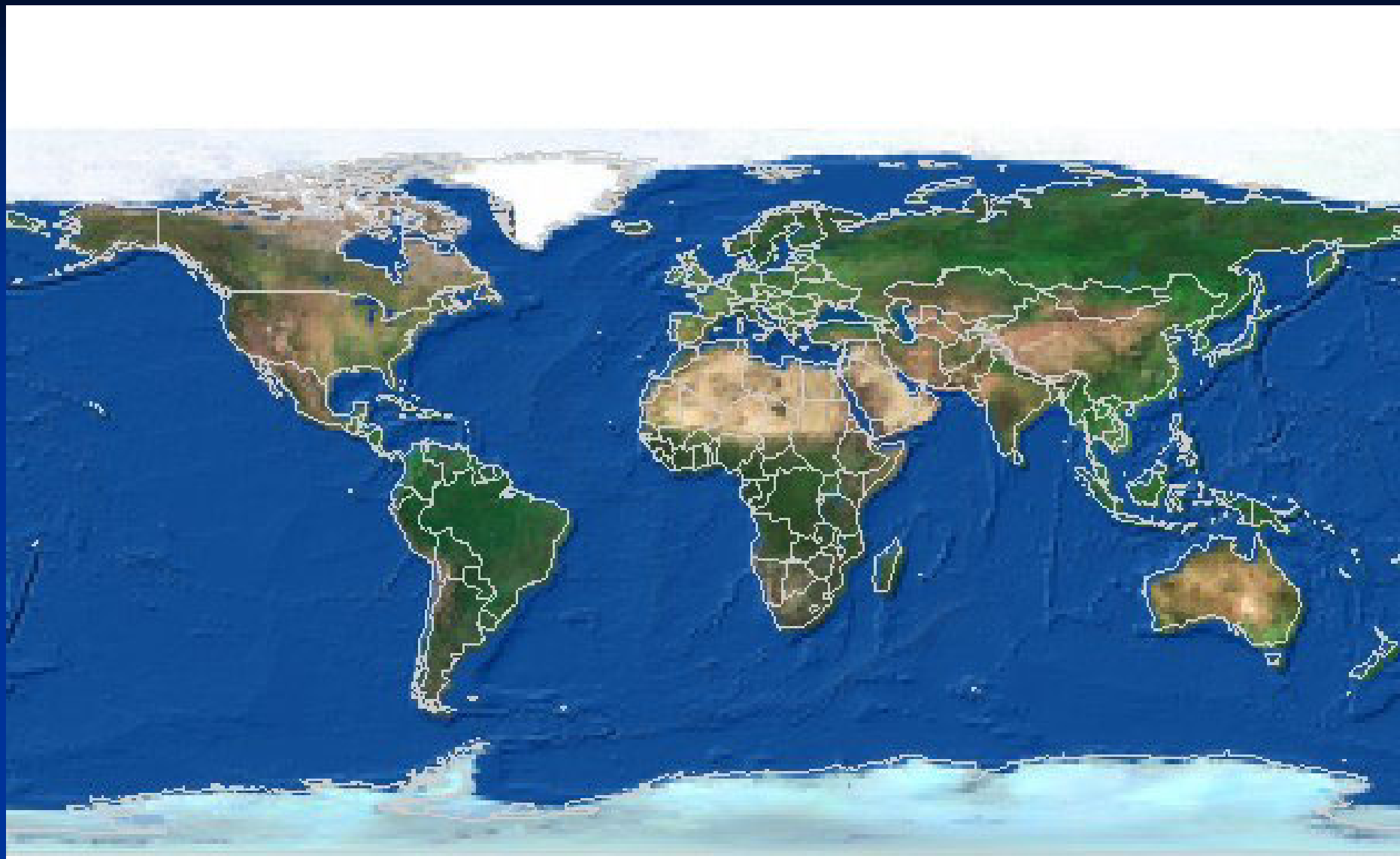
Preview

Making the right plan
- evidence based practice -
- standardized protocols and practices -

- Map of Medicine
  - 1000 pathways
  - customizable
  - point-of-care
- Joanna Briggs Institute
  - 1200 reviews
  - 200 care packages

Flawed execution

- On line monitoring
- Cued data acquisition
- Intelligent cascades
- Security management
- Aggregation and storage
- Analysis and solutions



www.mapofmedicine.com

www.jbiconnect.org

www.patientsafetyint.com/aims

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» Views

My Views

Past 12 Months Summary

Aggressive Incidents in 2006

Public Views

All Last 30 Days

Past 12 Months List

All Incidents

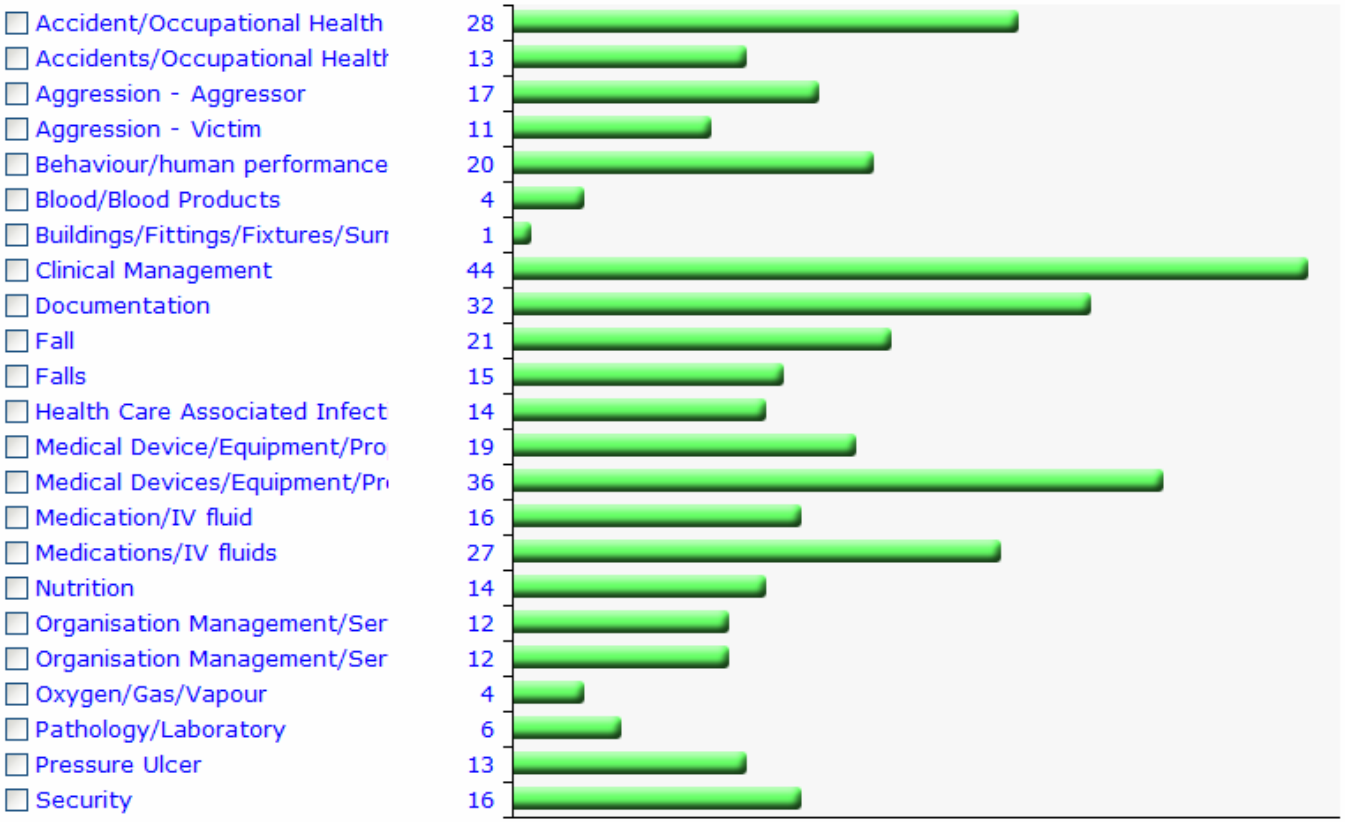
» Alerts

none

Incidents »

Incident List

Principal Incident Type | Trailing 12 Months | 1/8/2006 | 31/7/2007 | Go



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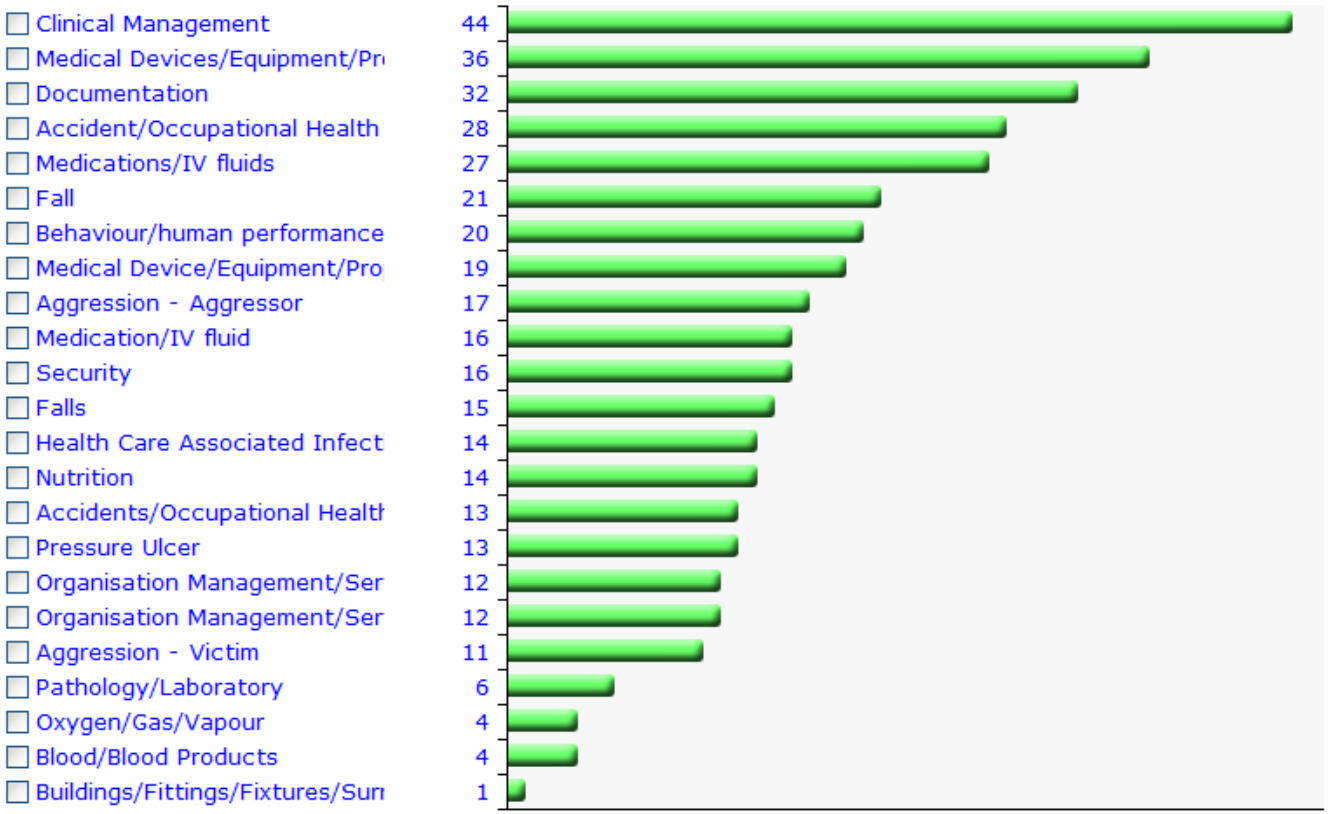

Total: 395

Percentage View | Default Order | Enter View Name | Save View

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none

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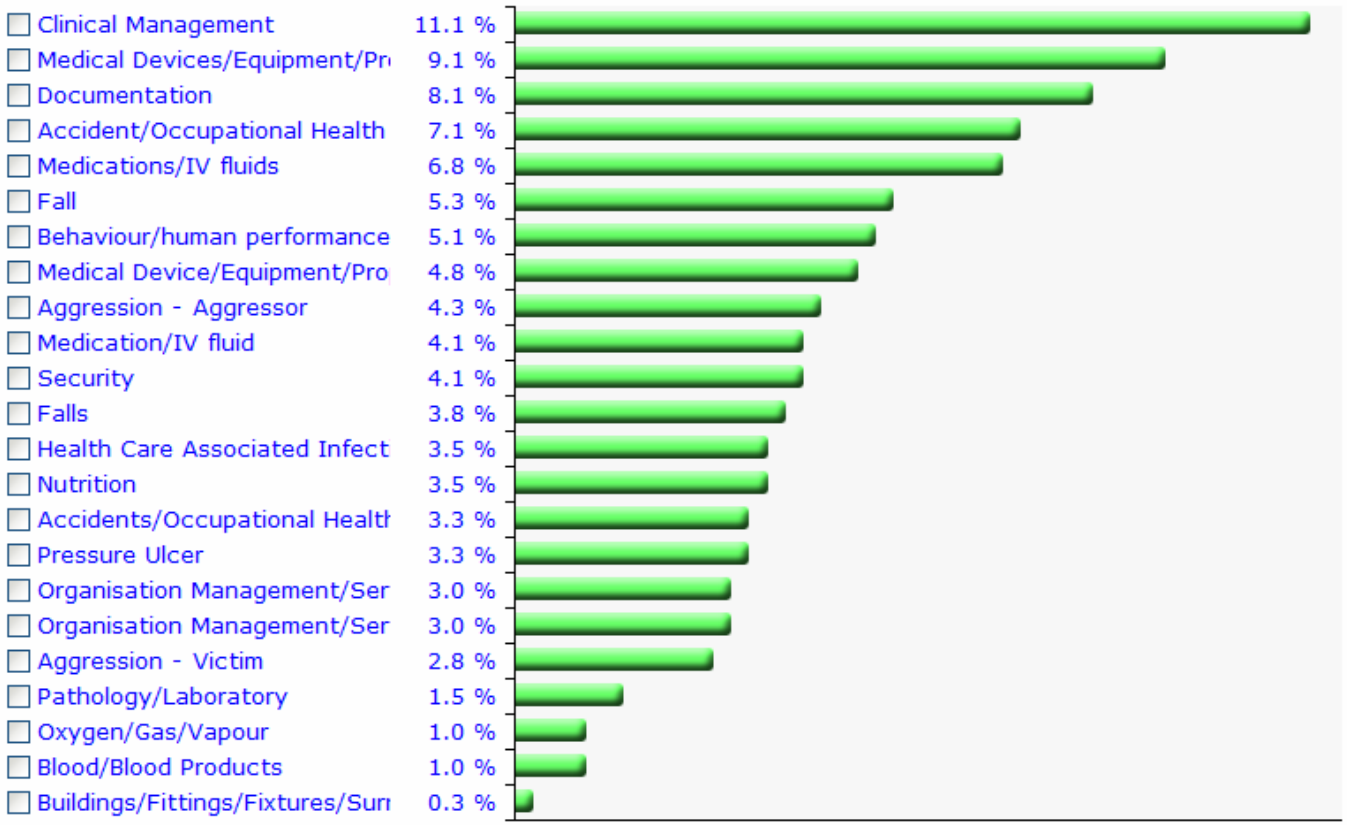

Total: 100.0 %

Count View | Default Order | Enter View Name | Save View

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Location - Statewide

Trailing 12 Months | 1/8/2006 | 31/7/2007 | Go

Western Area	35.7 %	
Eastern Area	64.3 %	

Total: 100.0 %

Count View | Percentage Order | Enter View Name | Save View

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none

Search full text of Incidents:

wheelchair Search

All Issues Current View

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» ALERTS

none

Search full text of Incidents:

wheelchair Search

All Issues Current View

All Issues Results **1** - **7** of **7** for "**wheelchair**"

605 *no First Name no Last Name* - 29/06/2007 - Investigate
Pt stated I am going to faint. Arrived in xray dept in **wheelchair**. Swaying in chair. Noted Hx unstable postural drop & Holter monitor ordered. Potential MET call.
Clinical Management *no sac*

550 Esme Robertson - 28/06/2007 - Complete
Client stated her shoe (rubber sole flat shoe) stuck on stairs and she fell on hand and knees (carpet floor).
Fall *no sac*

392 Gladys Knight - 8/05/2007 - New
Visitor entered patients bathroom to wash hands and slipped on wet floor in bathroom.
Fall *no sac*

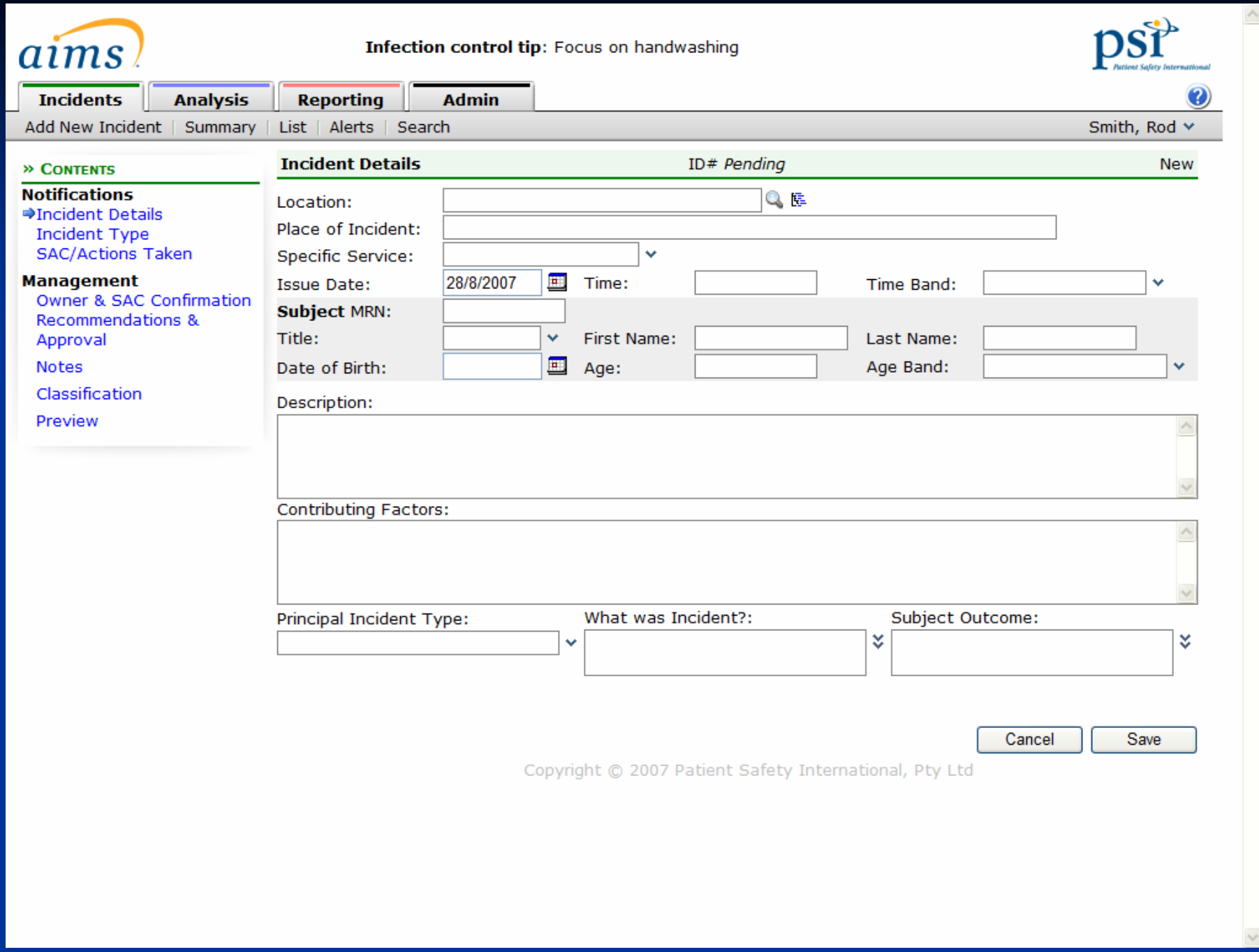
298 Carrie Richards - 9/12/2006 - Complete
Phone call from casualty that pt was dizzy, anxious and shaky. Arrived at scene and pt crying, SOB, tachycardia, skin cold and clammy, dizzy and not orientated TPP. Unable to stand up - **wheelchair** used to take pt back to ward. Obs done, Medical Cover notified. Pt had gon ...
Behaviour/human performance SAC 4

177 Catherine Rice - 12/01/2007 - Complete
Patient was drinking coffee when she spilt it in her lap. She was in the dining room & wheeled her **wheelchair** to the staff area & informed me. I threw water on her lap & informed the Dr who was standing there. Dr viewed the area affected.
Accident/Occupational Health and Safety SAC 3

111 Harold Turner - 18/12/2006 - Complete
Harold had been for surgery to nose with daughter. Returned to unit & had got out of car & fell backwards, sitting on his bottom in the car park.
Fall *no sac*

87 Susan Cole - 19/12/2006 - Complete
When putting resident back to bed after lunch I was moving her **wheelchair** away from resident and the foot rest touched her lower right leg and gave resident a skin tear.
Accident/Occupational Health and Safety SAC 4

1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Title:
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Last Name:
Date of Birth:
Age:
Age Band:
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Subject Outcome:
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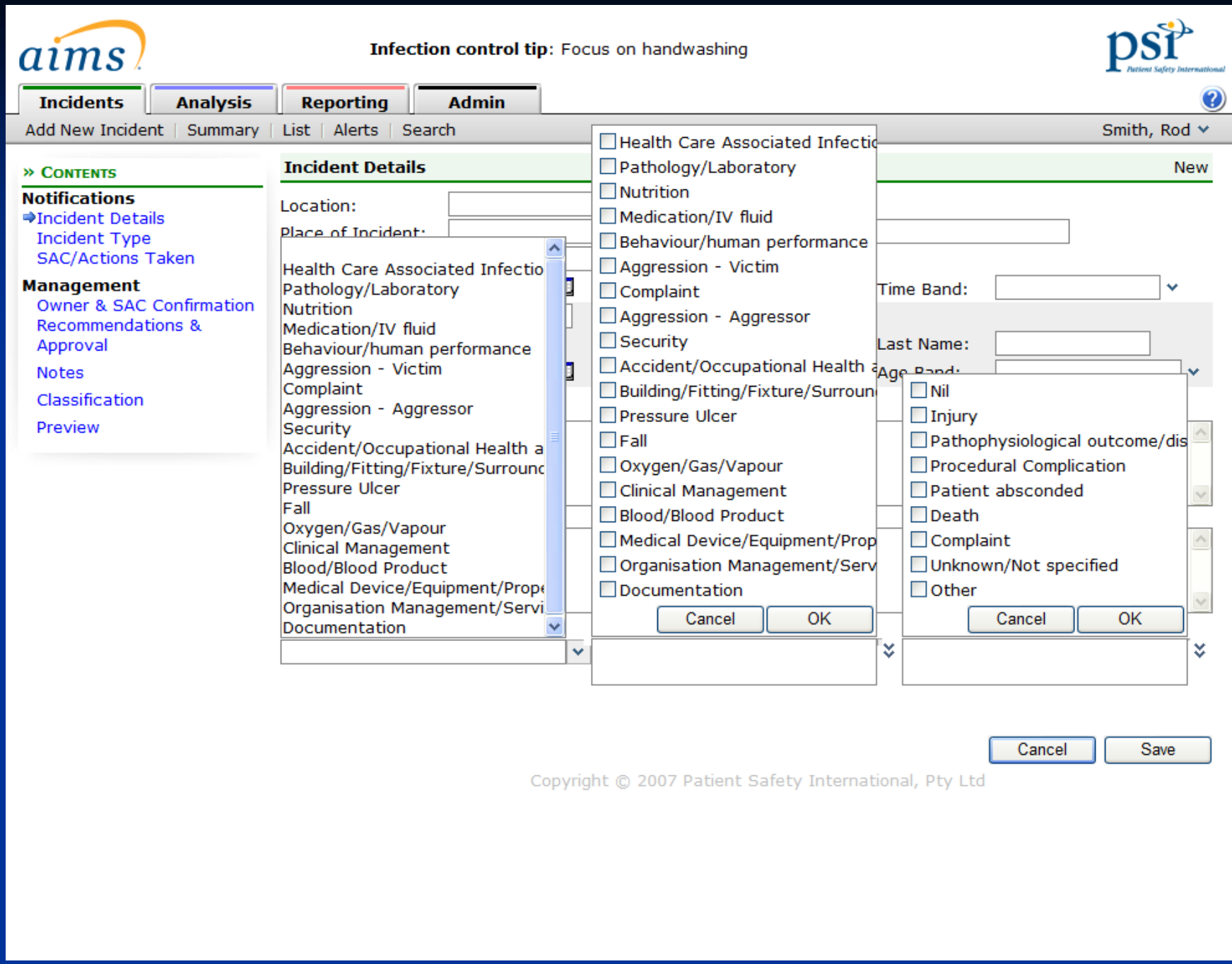
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Medication/IV fluid
Behaviour/human performance
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Complaint
Aggression - Aggressor
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Fall
Oxygen/Gas/Vapour
Clinical Management
Blood/Blood Product
Medical Device/Equipment/Prope
Organisation Management/Servi
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Health Care Associated Infectic
Pathology/Laboratory
Nutrition
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Behaviour/human performance
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Aggression - Aggressor
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Building/Fitting/Fixture/Surroun
Pressure Ulcer
Fall
Oxygen/Gas/Vapour
Clinical Management
Blood/Blood Product
Medical Device/Equipment/Prop
Organisation Management/Serv
Documentation
Cancel
OK
Nil
Injury
Pathophysiological outcome/dis
Procedural Complication
Patient absconded
Death
Complaint
Unknown/Not specified
Other
Cancel
OK
Cancel
Save
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Extract: Unknown

Analysis Grid

» Cubes and Reports

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Reports

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- Falls
- Falls Subject Moving
- Injury Location
- Injury Type
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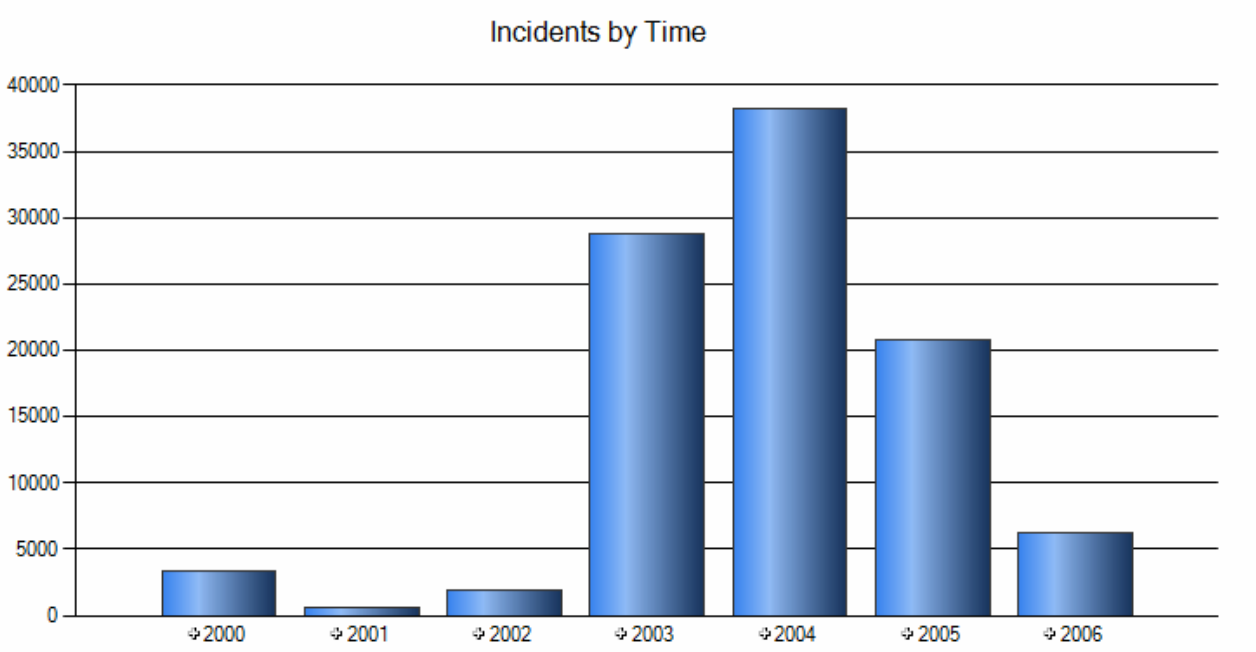
- Subject Activity
- **Time**

Show: Measures By: Time



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Smith, Rod

Extract: Unknown

Analysis Grid

» Cubes and Reports

Cubes

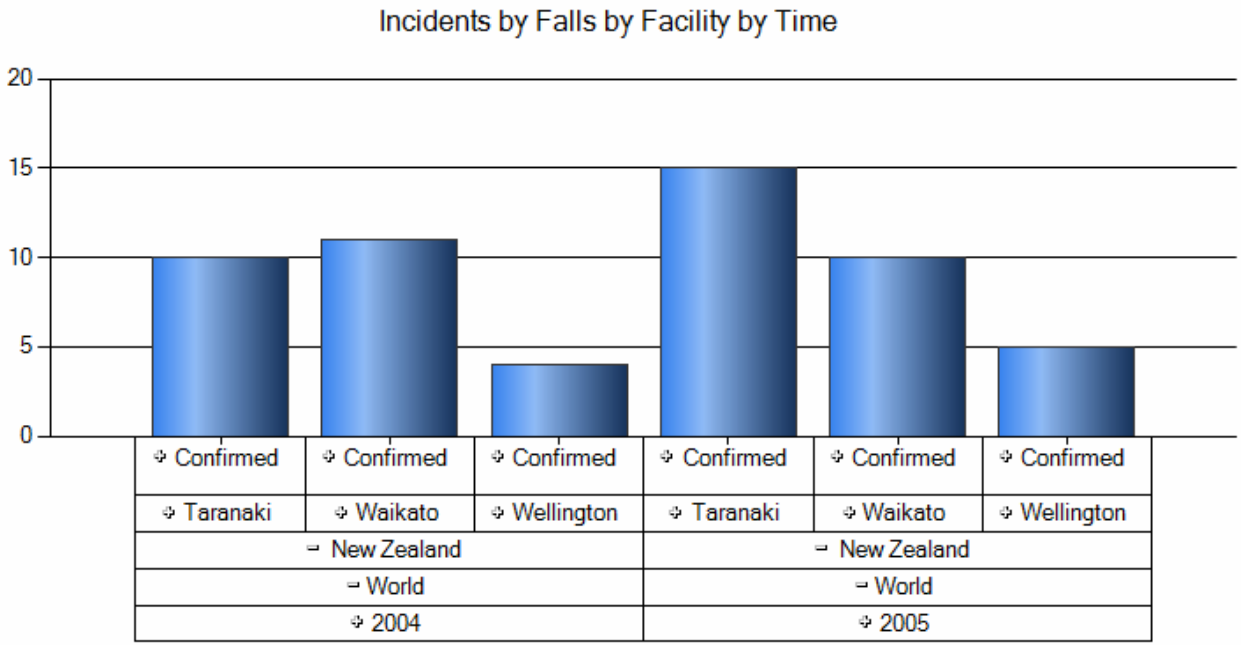
Incidents

Reports

none

Show: Measures

By: Time | Facility | Falls



» Dimensions

- **Measures**
  - **Incidents**
- **Facility**
- **Falls**
- Falls Subject Moving
- Injury Location
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- Medications
- Outcomes
- Principal Incident Type
- Subject Activity
- **Time**

Enter Report Nam | Save

aims

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Extract: Unknown

Analysis Grid

» Cubes and Reports

Cubes
Incidents
Reports
none

Show: Measures

By: Falls | Facility | Time

» Dimensions

- Measures
  - Incidents
- Facility
- Falls
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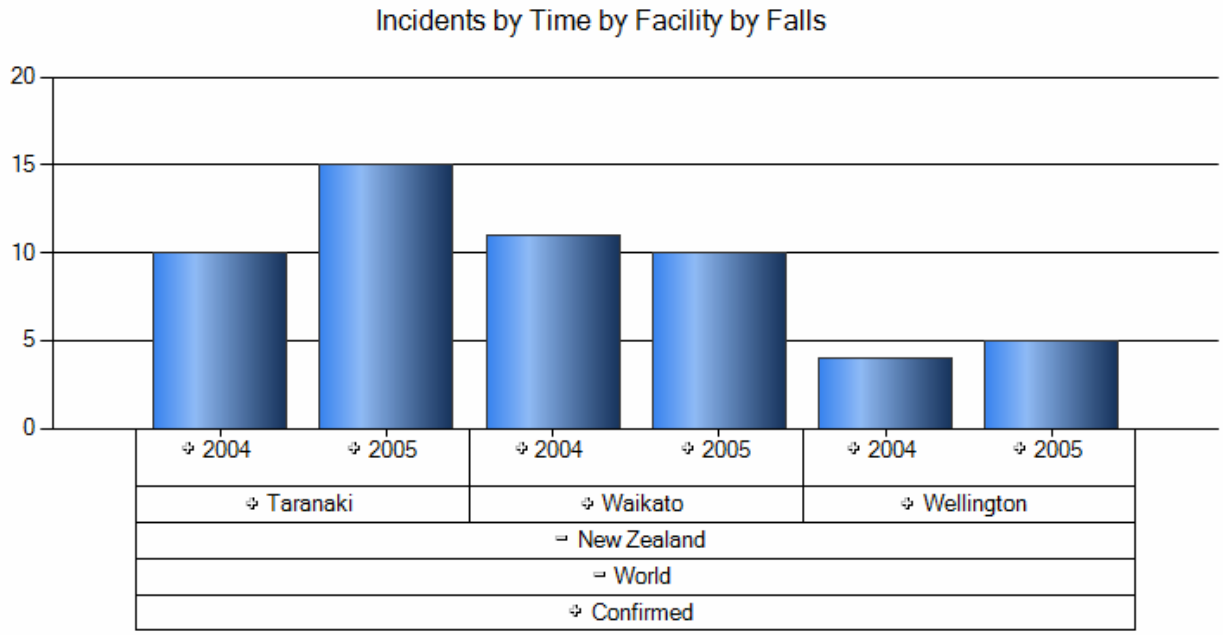
- Subject Activity
- Time



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Incidents | Analysis | Reporting | Admin

Summary | New Report | Schedules | Data Dictionary | Smith, Rod

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Medical Devices Last Month
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Medical Devices Last Month
Medical Devices Last Month
Test Report
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last

» REPORT LAYOUTS

Summary
Details
Summary Chart
Summary Chart with Details

1 of 1 | Find | Next | Select a format | Export

Medical Devices Last Month

24/08/2007 6:04:25 PM

Incident Status	Initial SAC	Total
⊞ Complete		1
⊞ Investigate		1
⊞ New		13
⊞ Review		3
	Total Incidents:	**18**

Security: Statewide

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aims

Infection control tip: Focus on handwashing

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none

Shared Reports

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Test Report
Medical Devices Last Month
Medical Devices Last Month
Test Report
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last

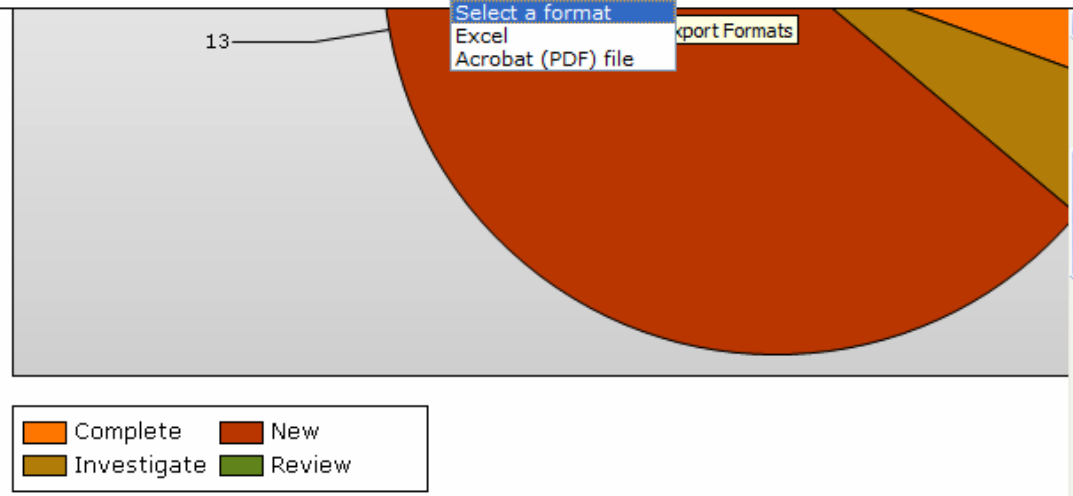
» Report Layouts

Summary
Details
Summary Chart
Summary Chart with Details

1 of 1 | Find | Next | Select a format | Export

Select a format
Excel
Acrobat (PDF) file

xport Formats



Incident Id	Location	Incident Status	Description
418	South Australia	New	Break down of Pathfinder machine for automat Delay in preparation of aliquots for testing.
532	Statewide	New	No keys to open shed where mechanical lifter onboard by carrying stretcher and lifting manu
556	Eastern Area	Review	Healthy 59 yo lady for septoplasty Induced Propofol 200 Fentanyl 100 Midazolam:

aims

Infection control tip: Focus on handwashing

psi Patient Safety International

Incidents | Analysis | Reporting | Admin

Summary | New Report | Schedules | Data Dictionary | Smith, Rod

» Recent Reports

My Reports

none

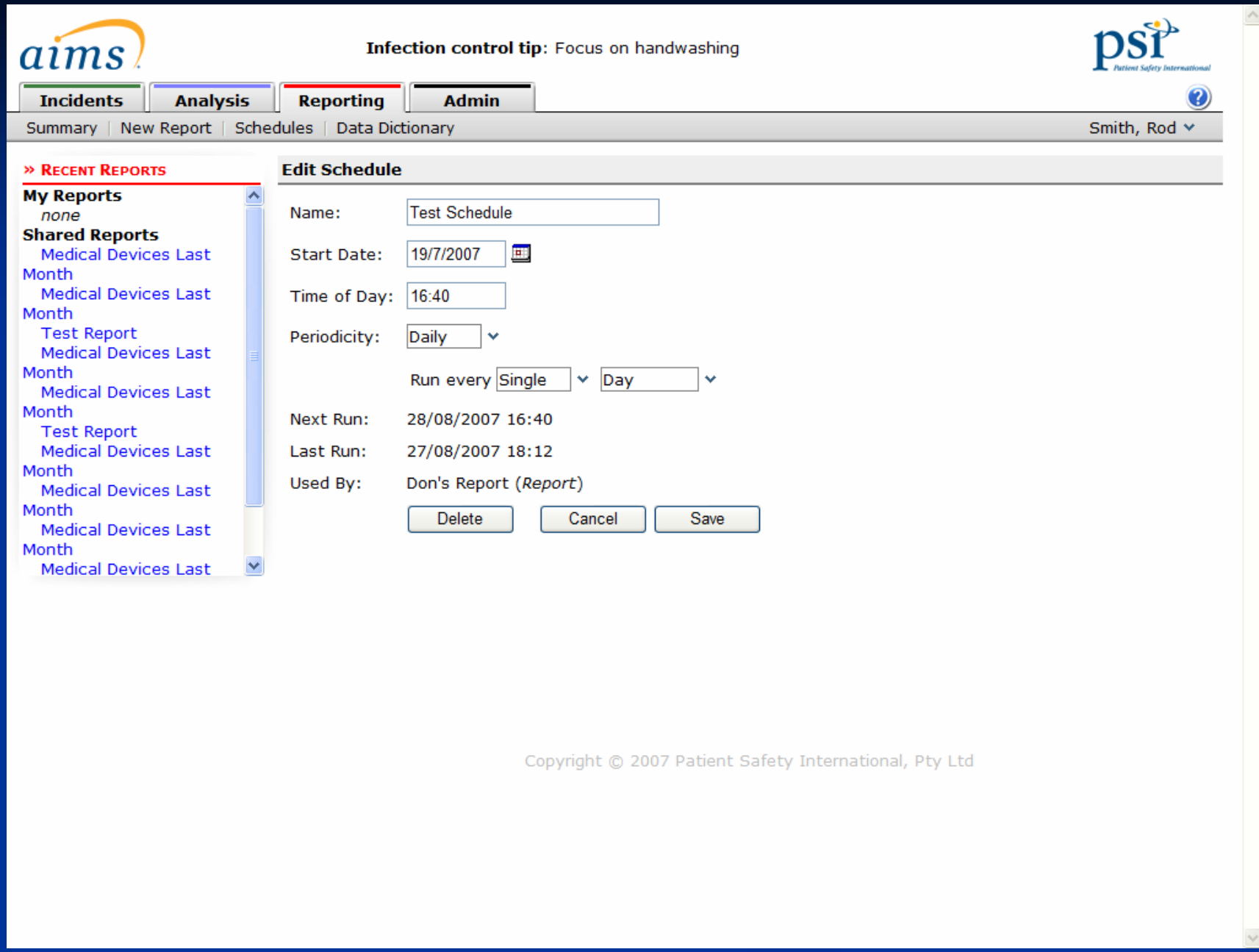
Shared Reports

Medical Devices Last Month
Medical Devices Last Month
Test Report
Medical Devices Last Month
Medical Devices Last Month
Test Report
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last

Schedule List

Name	Schedule	Time	Next Run Date	
Test Schedule	Run every **Single Day**	16:40	28/08/2007	Edit
Daily PM Run	Run every **Single Day**	17:50	28/08/2007	Edit
Weekly Schedule	Run every **3rd Day**	01:00	29/08/2007	Edit

Add New Schedule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Incidents
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Summary | New Report | Schedules | Data Dictionary
Smith, Rod
» Recent Reports
My Reports
none
Shared Reports
Medical Devices Last Month
Medical Devices Last Month
Test Report
Medical Devices Last Month
Medical Devices Last Month
Test Report
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last Month
Medical Devices Last
Edit Schedule
Name: Test Schedule
Start Date: 19/7/2007
Time of Day: 16:40
Periodicity: Daily
Run every Single Day
Next Run: 28/08/2007 16:40
Last Run: 27/08/2007 18:12
Used By: Don's Report (Report)
Delete
Cancel
Save
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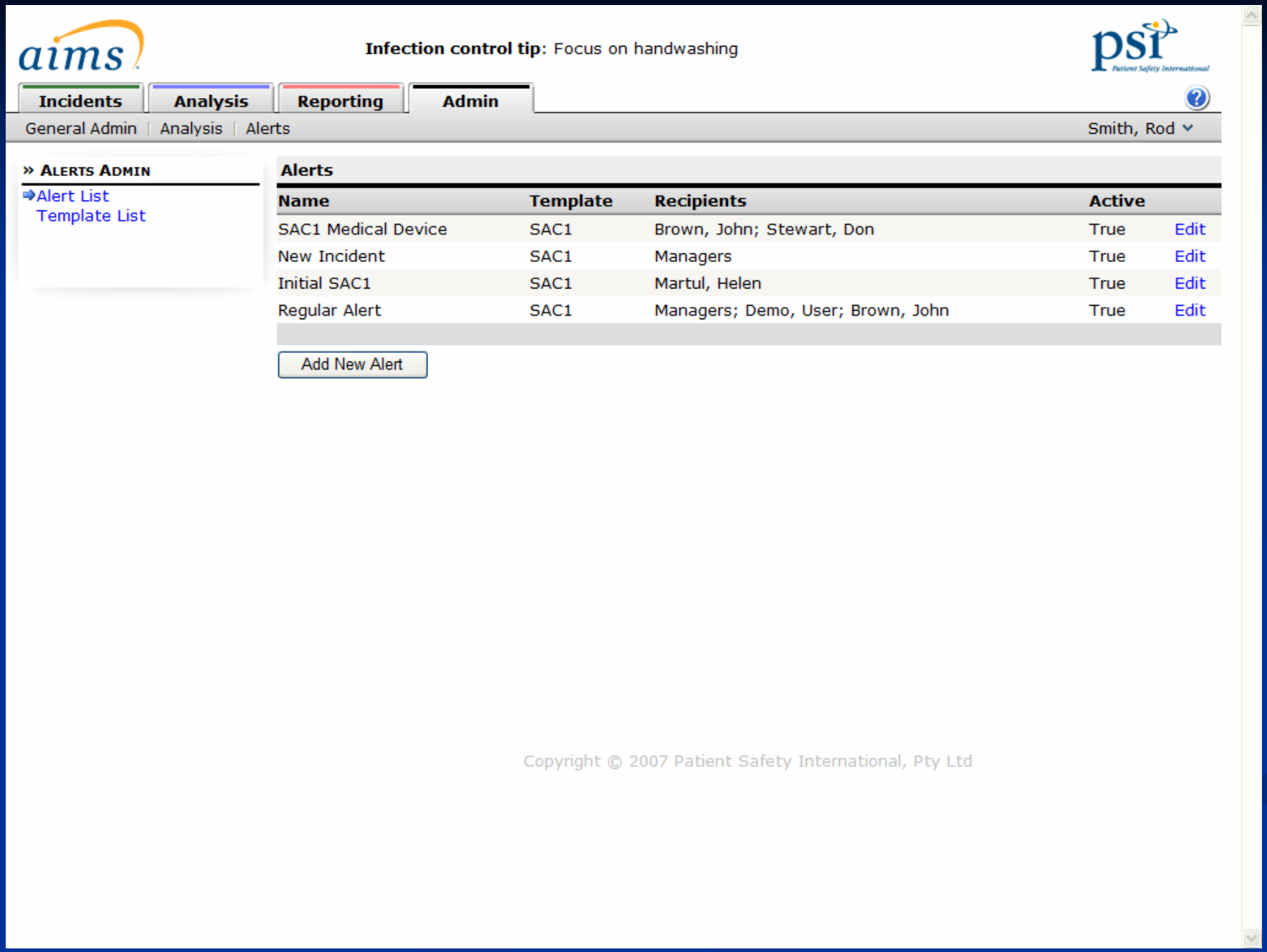
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Incidents
Analysis
Reporting
Admin
General Admin | Analysis | Alerts
Smith, Rod
» Alerts Admin
Alert List
Template List
Alerts
Name
Template
Recipients
Active
SAC1 Medical Device
SAC1
Brown, John; Stewart, Don
True
Edit
New Incident
SAC1
Managers
True
Edit
Initial SAC1
SAC1
Martul, Helen
True
Edit
Regular Alert
SAC1
Managers; Demo, User; Brown, John
True
Edit
Add New Alert
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ASP for Global Use – Version 4

- National, regional and local databases
- Elicits, stores, aggregates and analyses information
- Management of individual incidents
- Management of aggregated data
  (eg crisis management)
- Compendium of solutions
- Part of a suite of globally available web-based tools

The Joanna Briggs Institute & Australian Patient Safety Foundation Map of Medicine

- Close collaboration
- Right thing, right way, right time, by the right people
- Rigorous process to establishing 'right thing' – best available evidence, multi disciplinary, cultural context
- Future challenges – best mechanisms for evidence utilisation – implementation of evidence based guidelines; importance of clinical audit; consumer participation; IT systems integrated into workflow

Collaborating Centres of the Joanna Briggs Institute

(28 internationally)

- Fudan Evidence Based Nursing Center: Fudan University, Shanghai, People's Republic of China. Director: Professor Jia Hongli.
- The Hong Kong Centre for Evidence Based Nursing: at The Chinese University of Hong Kong. Director: Professor Diane Lee
- Taiwan Joanna Briggs Institute Collaborating Centre, Taiwan, National Yang-Ming University, Taipai, Taiwan R.O.C. Director: Professor Pei-Fan Mu
- Yonsei Evidence Based Nursing Centre of Korea, Yonsei University College of Nursing, Seoul, Korea. Director: Dr Euisook Kim.
- The Thailand Centre for Evidence Based Nursing and Midwifery, Chiang Mai University, Chiang Mai, Thailand. Director: Dr Wilawan Picheansathian.