DWK 76

Investigation – P 74

On 14 May 2003, Mr P 74 , underwent a gastroscopy, performed by Dr Jayant Patel at Bundaberg Base Hospital (BBH), for which he was not scheduled nor consented. Mr had been admitted to Day Surgery Unit (DSU) for a right epididymectomy to be performed by Dr Kingston on that day.

This error was identified by the Operating Theatre (OT) staff and reported to Dr Kingston, Mrs Goodman, Director of Nursing, Dr Keating, Director of Medical Services and Mr Leck, District Manager. Mr . eceived an apology on the day of the incident from Dr Kingston, on behalf of the hospital.

He underwent his expected procedure and was discharged home. Mr P 74 rang the next morning and spoke to Dr Keating. He expressed his concerns about the incident wondering how it had happened, where was his medical record and what may have happened if he had an allergy that wasn't known by staff. He noted that no body part was removed nor injury received during the gastroscopy, but clearly understood the major implications of this incident. Dr Keating apologised again for the incident, explained that the incident would be investigated to establish the system failures with a view to reducing the likelihood of this happening again by implementing changes to policy and procedures as required. Mr P 74 was invited to write a letter outlining his concerns and possible areas that may have contributed to this incident. It was explained that the results of the investigation would be made available to him. No letter was received from Mr P 74 Multiple attempts to contact Mr . P 74 by phone were made, before he phoned to say that he was working in Gladstone. An appointment was made for 15 August 2003.

An investigation was undertaken conjointly by Ms White and Ms McDermid, Nurse Practitioner Consultants OT and DSU, into this incident. The results were communicated to Mrs Goodman and Dr Keating.

Major findings:

a. normal process to move patients from DSU to OT for endoscopy was not followed,
b. no handover between DSU and OT nursing staff occurred,
c. no proper identification process of patient by nursing staff in DSU or at OT occurred, and
d. no formal checking of patient's identification in OT occurred.

Major changes

a. At least one DSU nurse to be on duty at all times during hours of business,
b. Ensure all DSU patients undergoing operative procedure handed over by DSU staff to OT staff,
c. Formal patient identification and name checks to occur in DSU and OT,
d. Use of perioperative record with pre-op checklist (which includes patient identification) for all DSU patients undergoing operative procedures,
e. The employment of a Registered Nurse to carry out reception duties in OT, which encompasses double checking of patients before going into the operating room proper.
f. Education of staff about incident, new policy and reinforcement of normal protocol regarding reception of patients into OT area, and
g. Follow-up of policy changes to review effectiveness in six months.

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Other Issues

a. Apology to Mr 974 to be reinforced at meeting on 15 Aug 03,
b. Explanation of systems approach to rectifying problem of human error, and
c. Education of staff to increase awareness and develop learning.

Dr Darren Keating
DMS

12 Aug 03