

Manitoba Health, Seniors and Active Living (MHSAL) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Delay in Treatment

Summary:

A patient was repatriated to the facility following an abdominal aortic aneurysm repair. The plan was for occupational and physical therapy follow up prior to discharge. The patients' oxygen saturation decreased significantly without responsible physician being notified.

The patient deteriorated drastically before the attending physician was notified. The patient was transferred to the Special Care Unit. When it was determined that the patient's advanced care plan indicated no ICU admission, the patient was transferred back to inpatient unit for palliative care.

The patient died within an hour of the transfer.

Keywords:

Delay in Treatment

Findings of the Review:

Staff were not aware of Special Care Unit & Rapid Response Physician (SCU/RRP) policy.

Chart review demonstrated insufficient documentation; the standards for documentation were not consistently followed.

A lack of relevant clinical information was communicated to the consulting physician so a clear understanding of the patients status was not possible.

System Learning:

Develop an education plan for staff to ensure Special Care Unit & Rapid Response Physician (SCU/RRP) policy is implemented regionally.

Develop a process for the Chief of Staff in each site to perform regular chart audits to ensure documentation and standards of care are being met.

Develop regional education for nursing staff in using the SBAR tool to ensure that relevant information is communicated to the physicians and other care providers.

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