

CLINICAL PROCEDURE SAFETY

LEVEL 1 PROCEDURES – 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 - Imaging

A patient was taken to the Medical Imaging Department for a carotid Doppler ultrasound. The patient's full name and date of birth were not checked by transport staff or sonographer.

The ward nurse had not been asked to check the patient's identity on collection. The patient answered to an incorrect first name and the patient identification band was not checked to correctly identify the patient.

ACTION REQUIRED

- Before commencing a procedure, the patient must be asked to state their full name and date of birth.
- The patient's response must be verified against details on the request form and patient identification band.

Case 2

Identifying the Patient – Expressed Breast Milk

A midwife working in a nursery prepared expressed breast milk (EBM) for two babies who were due for feeds. Both bottles of EBM were clearly labelled and placed next to one another on the bench near the babies' cots.

The identity of the baby was not checked against the EBM and the incorrect bottle of EBM was handed to the mother.

ACTION REQUIRED

- Two members of staff, or one member of staff & the mother if appropriate, should always undertake identification of the EBM & check the baby's identification bands.
- NSW Health *Maternity - Breast Milk: Safe Management*, PD2010_019

Case 3

Identifying the Patient – In the ED

Two elderly patients presented to the ED by ambulance at the same time. One patient had a history of dementia and the other with no cognitive impairment, however both had a history of falls.

They were placed by the ambulance officers in beds 1 and 2 but not as allocated by the NUM in the First Net system. Patient A was placed in patient B's bed and patient B was placed in patient A's bed.

A clinical handover at the bedside was attended between the ambulance officers and the nurse looking after the patients. Clerical staff placed notes with stickers as per First Net bed allocation.

Patient B was labelled with patient A's information and received a CT scan ordered for patient B. The Radiographer attending to a mobile chest x-ray on patient A found a discrepancy with patient A's date of birth during patient identification and alerted staff to the mislabelling of patient A.

Correct identification and re-labelling of each patient was attended.

ACTION REQUIRED

- Patient identification must be confirmed before any procedure commences.