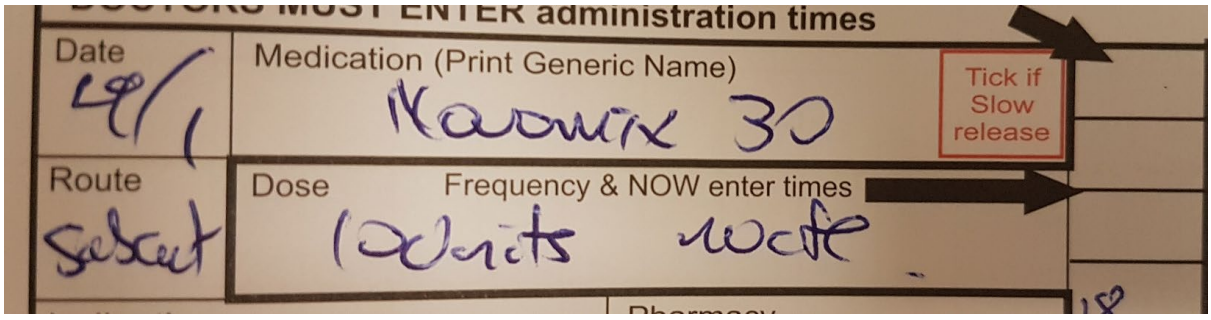
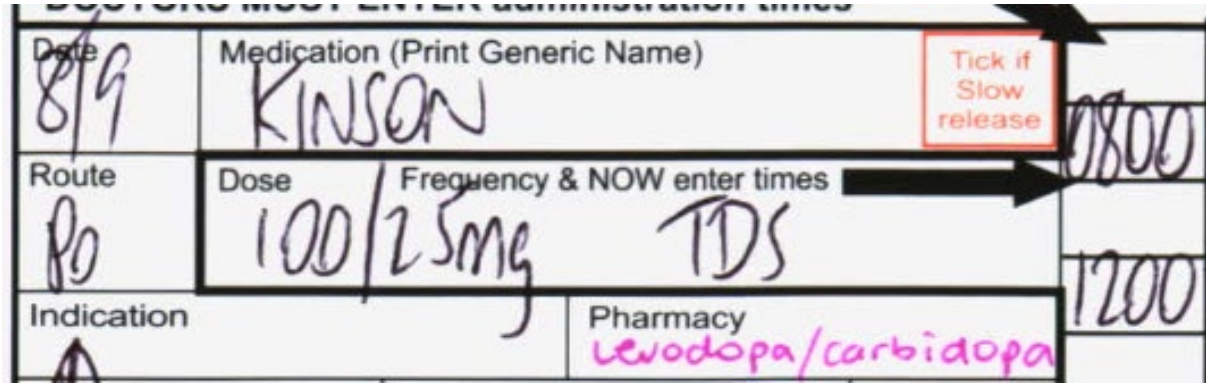
Case Study

Quality and Patient Safety, Infection Prevention and Control and Medication Safety (Pharmacy)

Mr Santiago is a 78 y.o. overseas resident of Spain who has had 5 admissions over the past year in a Madrid Hospital for chronic respiratory infections and asthma. In addition to his respiratory issues, his relevant medical history includes Parkinson's, Type 2 Diabetes and Rheumatoid Arthritis. Mr Santiago walks with a single point stick which helps his balance, especially when he gets a bit short of breath on longer walks. Mr Santiago arrived in Melbourne 4 days ago and is staying with his daughter and son in law, and does not speak any English.

Mr Santiago presents to the Emergency Department febrile, with increasing lethargy and increased cough. He is accompanied by his grandson (20 years old). In the Emergency Department (ED), the clinical team direct their questions to the grandson (who does not live in the household). The grandson is very careful to inform the medical staff of his grandfather's previous adverse reaction to penicillin. The pharmacist in ED completes a medication management plan using the patient's own medications (which only have instructions in Spanish), and with the help of the grandson. A medication chart is completed by medical staff in ED.





Date	Medication (Print Generic Name)	Tick if Slow release											
4/5	MTX												
Route	Dose Frequency & NOW enter times												
O	10mg Fridays		12	TH	TH	TH	TH	TH	TH	TH	TH	TH	TH
Indication	Pharmacy												
Prescriber Signature	Print Your Name	Contact											
J. Smith	SMITH												

Mr Santiago is assessed by the ED team and admitted under general medicine.

He is transferred to an in-patient bed in a shared 4 bedroom. The nurse allocated to Mr Santiago completes all the admission risk assessments shortly after he arrives onto the ward. Included in this process is the falls risk screening and assessment tool (FRAT). The screening reveals that Mr Santiago is high risk for an in-hospital fall and the nurse identifies a number of suitable risk reduction strategies to minimise this risk. One of these strategies is placing his walking aid (walking stick) within reach of his bed. The nurse also provides Mr Santiago with a detailed brochure on clinical risk reduction and falls prevention. His observations are documented in the observation and response chart (ORC) and weight (120kg) documented on a weight chart. These are placed in the risk assessment section in the blue bedside folder.

Mr Santiago is then seen by the medical team on their daily ward round. Mr Santiago is assessed for VTE risk on the VTE risk assessment tool by the general medicine intern and determined to be at moderate risk of developing a venous thromboembolism as an in-patient. Enoxaparin 40mg subcutaneously once daily and TEDs are prescribed as thromboprophylaxis. During the round, they note Mr Santiago is a bit more confused than before, so the team use the grandson as interpreter. One of the questions is about how many times Mr Santiago goes to the toilet per day, which the grandson chooses to answer without asking his grandfather as he is embarrassed. The results of the urine screen requested in ED are not yet available. The medical team decide that Mr Santiago needs a course of intravenous antibiotics – Tazocin® to cover all possible microbials and the medication is written up on the medication chart.

During the course of the next night, Mr Santiago wakes up and needs to go to the toilet. He looks around and sees his walking stick leaning against the far wall of his room. He gets up to walk over to his walking stick and falls, resulting in a laceration on his knee. The overnight staff hear the noise and help Mr Santiago back to bed where his injury is assessed. The laceration requires suturing by the Night RMO. During the procedure, the RMO sustains a needlestick injury. A note is made in the progress notes to have the medical team review Mr Santiago's knee in the morning. The staff do not record the fall in Riskman and consider that they do no need to contact Mr Santiago's family to let them know about the fall. Targin® together with regular paracetamol and PRN pain relief/antiemetics are prescribed for the patient's considerable pain.

Year 20 22 Nam

Date	Medication (Print Generic Name)				Date
4/5	Paracetamol				
Route	Dose	Hourly frequency	PRN	Max dose/24 hrs	Time
O	1g	q4h			
Indication		Pharmacy			Dose / Route
Prescriber Signature	Print Your Name		Contact		Sign
J Smith	SMITH				

Date	Medication (Print Generic Name)				Date
4/5	Morphine Liquid				
Route	Dose	Hourly frequency	PRN	Max dose/24 hrs	Time
O	2mL	q4h			
Indication		Pharmacy			Dose / Route
Prescriber Signature	Print Your Name		Contact		Sign
J Smith	SMITH				

Date	Medication (Print Generic Name)				Date
4/5	Maxolon				
Route	Dose	Hourly frequency	PRN	Max dose/24 hrs	Time
O	10mg	qid			
Indication		Pharmacy			Dose / Route
Prescriber Signature	Print Your Name		Contact		Sign
J Smith	SMITH				

Early the next day, the patient is placed in Contact Precautions by Infection Control.

Later that day Mr Santiago's family visit and

1. Notice the bandage on his knee from the fall the night before. Mr Santiago is unable to remember what happened in detail but can remember falling.
2. Note the patient has moved beds to a single room, is in contact precautions and the family were not notified why

The family question the nurse looking after Mr Santiago who is unaware of the fall as it had not been handed over to them that morning and was not recorded in RiskMan.

The family become quite angry at what they perceive is poor quality care and request to speak with the Nurse Unit Manager (NUM) and the registrar. The NUM arranges to meet with the family after lunch, by which time the family are very upset. In the meeting, the son in law starts shouting at the NUM and registrar who quickly call a code black. The security guards arrive and suggest the son in law calms down or will be escorted from the ward. Eventually, the son in law calms down, and the NUM explains what occurred the previous night and apologises to the family that they were not called. They explain why they think Mr Santiago fell and what they have put in place to reduce the risk of another fall.

Mr Santiago's in-patient stay is further complicated by the development of an irritating rash on his torso, episodes of hypoglycaemia, dizziness, confusion and severe "stuck moments" associated with his Parkinson's disease.

One week following admission Mr Santiago's renal function has deteriorated and he was noted to be thrombocytopenic and leucopenic.

How did we do?

1. What piece of previous medical history was overlooked? (IPC)
2. What issues can you identify in the way we communicated with Mr Santiago? (QPS)
3. What were the key clinical risks that were identified upon admission- what did we do to manage these? What is medical staff responsibility for fall prevention? (QPS)
4. When should open disclosure take place? What is your role in this? (QPS)
5. What is required under the new Statutory Duty of Candour legislation, does this incident qualify for the SDC process? (QPS)
6. What is the medical team's role in responding to patient and family complaints? (QPS)
7. What is the process for reporting and managing a needlestick injury (Occupational Exposure)? (IPC)
8. What PPE is required for Contact Precautions? (IPC)
9. Why is Mr Santiago experiencing episodes of hypoglycaemia? (Pharmacy)
10. Why has Mr Santiago's Parkinson's symptoms worsened? (Pharmacy)
11. Why else might have Mr Santiago's Parkinson's symptoms worsened? (Pharmacy)
12. Why has Mr Santiago's renal function worsened and his haematological parameters deteriorated? (Pharmacy)
13. Did Mr Santiago receive the correct dose of enoxaparin for thromboprophylaxis? (Pharmacy)
14. What might have caused Mr Patient's rash on his torso? (Pharmacy)
15. What did you think of the choice of antibiotic? (Pharmacy)
16. Can you identify any issues with the pain relief charted for Mr Santiago? (Pharmacy)