OHRI Cases

OHRI Cases: April 25, 2018

These training cases were developed for the CIHR-funded study “Testing the World Health Organization’s 11th Version of ICD” led by Cathy Eastwood, Danielle Southern, Alicia Boxill, Bill Ghali, Hude Quan, underway at the University of Calgary, Department of Community Health Sciences. This study involves coding 3000 full inpatient discharge records using ICD-11.

These cases were reviewed by Cathy Eastwood.

Codes were updated as of April 21, 2018.

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1	Patient brought in for CT Thorax Pulmonary angiogram. Contrast injectors were filled and lines were flushed with fluid. Procedure was carried out without incident. DI Technologist was notified by the radiologist that an air embolism was seen in the pulmonary trunk of the patient - likely iatrogenic from IV contrast administration. Recommendations: When connecting a new patient extension line to the contrast injector, purge all air from line before leaving injector. F/u reminder to all CT staff	
2	Patient had more than 1 hour delay before ECG was performed. Was immediately found to have an acute inferior MI upon completion. System Issues: Lack of resources for ECG at triage	
3	Patient had to use bathroom, was connected to cardiac monitor, rang call bell. However, all nurses were busy with other patients. Patient states he asked Family Medicine resident for assistance because no one else was around and she stated she could not help him. As a result, patient attempted to ambulate, slipped on floor and fell. Due to the fall, patient suffered laceration and bump to back of head, but denied losing consciousness and remained neurologically intact.	
4	Patient arrived to CT department for an enhanced chest scan. Patient was asked related questions prior to the contrast injection and gave consent, IV that was in place was flushed with saline and appeared to be in working order. Did an injection of 50cc of contrast and 20cc of saline for the scan, patient didn't complain of any discomfort. After reviewing images noticed that there was no contrast on the images, then checked the patients arm and noticed the injection had gone interstitial. A cold compress was applied and the IV was removed.	

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5	In the evening patient started to complain of pain to his IV site on top of the right forearm. Nurse tried to flush, fluid leaked therefore she removed the IV (saline lock). After doing so, nurse noticed that the plastic cannula was missing. Ultrasonography of right forearm done and cannula located within patient's vein. Patient will be followed up in vascular surgery clinic. Decision was made to monitor.	
6	Patient had 6 hour surgery in left lateral decubitus position. Gel roll for axillary support not available, therefore staff substituted 1L bag of IV fluid wrapped in green towel. At the end of procedure, anesthesia resident noted formation of multiple small blisters (2-4mm) at points of contact with roll in the axillary region caused by pressure. No skin breaks noted.	
7	Patient had his foley catheter removed early in the morning and patient did not void all day. As per day nurse, bladder scans done multiple times throughout day and there was always a residual of < 65 ml in bladder. No action taken. Bladder scanned by night RN in the evening and had over 1 litre in his bladder. Patient complaining all day of pain and pressure to suprapubic area. Physician notified and foley inserted. Immediate urine flow of over 2 litres.	

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8	Patient had an amiodarone infusion going through a peripheral line in the right forearm that went interstitial. Patient's arm was swollen and sensitive.	
9	Patient here for hip resurfacing arthroplasty. Patient grounded using megadyne pad on mattress for cautery. Cautery set at 60 cut, 60 coagulate. Upon starting the case surgeon stated that coagulation was not working and requested to turn it up to 80 coag. Nurse turned cautery up as per request. A few minutes later, surgeon stated cautery was not working again and requested new cautery. Circulating nurse was opening new cautery when anesthetist stated that megadyne pad had caught fire. There were flames approximately one foot off the bed, right in front of patient's face. Anesthetist attempted to put out fire by smothering it with pillow. Circulating nurse obtained sterile water from scrub nurse's setup and gave to anesthesia who then poured it on fire. Fire was extinguished. Patient's armband was black from fire. Patient's arm had black soot on it but no burns or injuries. Bottom sheet on bed, part of mattress at head of bed, megadyne cord, cords from BP cuff, O2 sat probe, ECG cable cord and O2 mask tubing all had been scorched by fire.	
10	Patient reported to writer that she has a burn and rash on shoulders after her Cesarean section. Obstetrician paged and made aware and ice applied to shoulder blades. Patient informed writer that she stated to anesthesia during procedure that she felt burning. It was determined that it was indeed an electrocautery burn it should have been detected in OR and immediately investigated. Patient suffered first and second degree burns to back, bilaterally over scapular area.	

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11	Patient was declared missing and was confirmed by police to have died by suicide the next day. This event occurred outside of the hospital, in the community.	
12	The patient was anesthetized and positioned, when the scrub nurse noticed bioburden on the Jordan perineal bookwalter retractor, during a review of her surgical instruments prior to the start of the surgery. After discussion with the surgeon, surgical team and MDRD supervisor, it was decided the surgery could not proceed without the specified retractor. The coordinating care facilitator was called, and after discussion, the surgery was officially cancelled, and the patient was woken up and sent to the PACU.	
13	Patient received for care in 4 point restraints. Upon reassessment of patient's mood, restraints removed as patient's status changed. Redness and indentation marks noted on patient's wrists indicating that restraints were put on too tightly. Patient reporting feeling a tingling sensation on both his hands. Will continue to monitor. Writer instructed patient to let his nurse know next time restraints are on too tightly.	

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14	Patient is on log roll precautions only as ordered by team (unless wearing TLSO), and has been on these precautions for over a week. Patient can only tolerate Thoracolumbosacral brace for 2-4 hours a day, so is laying flat on her back for most of the day, and cannot be repositioned off back. New today, the patient has developed a Stage II pressure injury on her left upper buttock, close to her coccyx. Fam med resident notified. Pressure injury dressed with foam tegaderm.	
15	Incorrect count of sutures. Count sheet read 41, counted 40. Thorough search of sterile field, ground and sponges completed. X-ray completed and cleared by Radiologist.	
16	Writer was assisting patient in shower room to wash her hair as she has a large craniotomy incision. Writer left the shower to make patient's bed as patient able to wash herself in shower room. RN walked by shower room and heard a noise, went into shower room immediately to find the patient laying flat on her front on the floor. Patient was alert, talking, stated she did not remember what happened. Neurosurgery resident on call happened to be on the unit at that time and came to the shower room immediately and assessed the patient. 4 staff members helped the patient up to a chair and brought her back to her bed. No injury, VSS	

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17	Patient brought to the washroom as requested. Placed on the toilet by RN and door left half closed. Health care aid was asked by RN to care for patient but health care aid and RN were busy and by the time they came back, patient had fallen.	
18	Patient admitted through ER from home. No MRSA screening was done on admission. MRSA was identified 4 days later by clinical specimen. Since then it has been identified that patient was already MRSA positive from another hospital. MRSA admission screening done on admission would have identified this & limited the time that patient exposed other patients.	
19	CBC specimen mislabeled. Specimen does not belong to this patient.	
20	Blood drawn and potassium results critical. Did not receive a page on the floor with results.	

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21	Patient given Gentamicin 100mg/100ml over 20 minutes IV instead of Flagyl 500mg/100ml IV at 2110. The Gentamicin had a Flagyl 500mg/100ml label with patients info. This error was caught at 0500 when RN about to administer 0600 dose noticed the IV bag was Gentamicin with Flagyl pharmacy label on it. Patient given 1 dose of gentamicin in error.	