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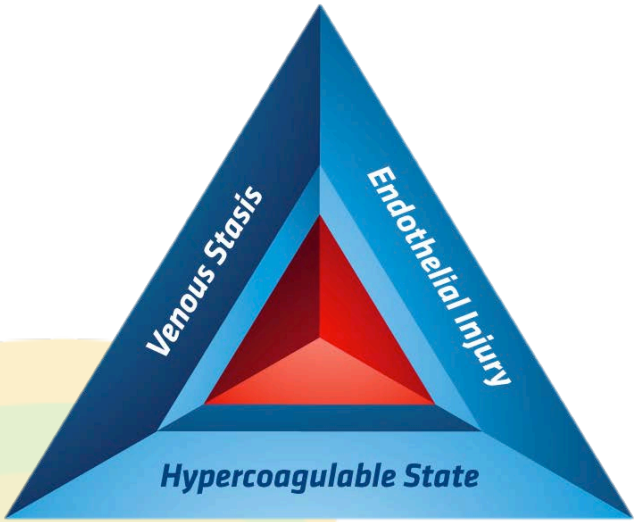
Perioperative harm

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

National Patient Safety Campaign

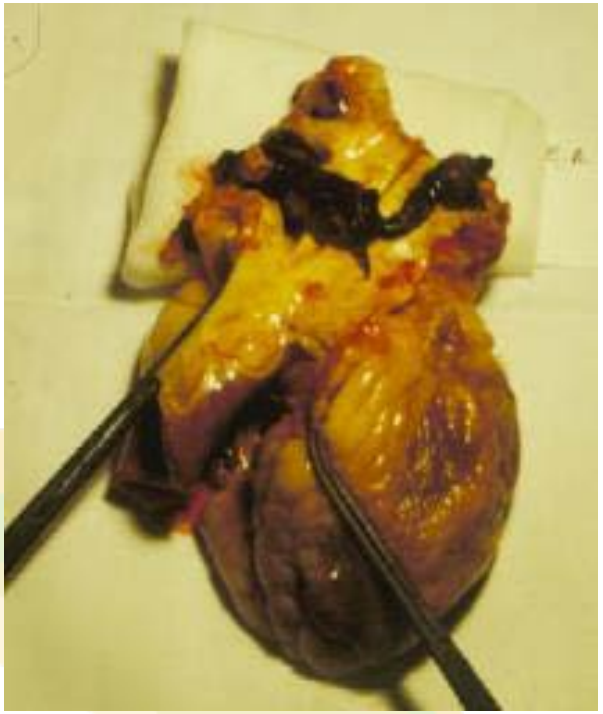
Case 1

- 55 year old woman has abdominal surgery in a private hospital
- Sepsis develops and the patient is transferred to a large DHB
- Presumption that patient had had VTE prophylaxis but in any event no risk assessment (would have been high) in DHB and no VTE prophylaxis



Case 1

- Patient in hospital a week and has two operations
- Some pulmonary complications and intermittent low saturations
- Patient has a sudden collapse and dies from massive PE



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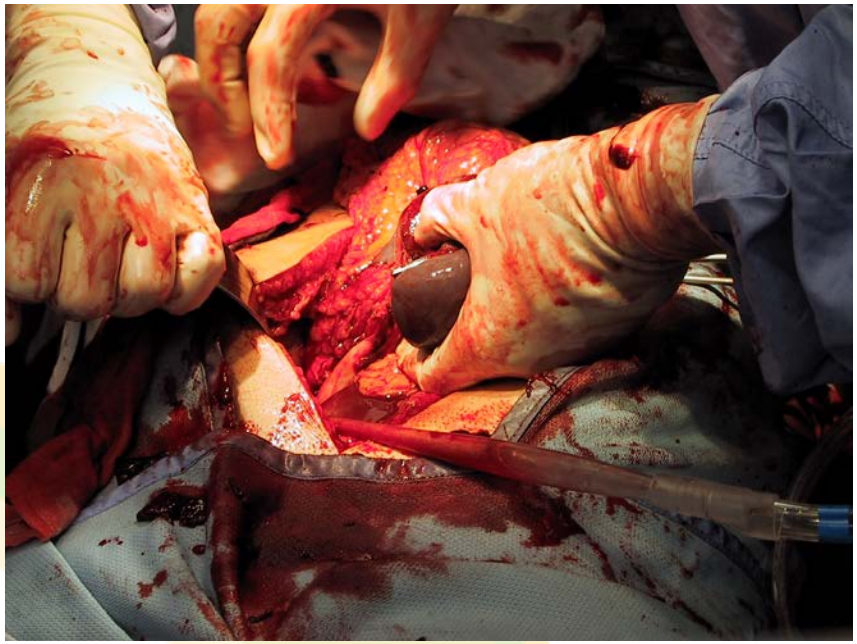
Case 1: Group task

- Where does the responsibility lie for the omissions in this case?
- What system(s) would you put in place to avoid a recurrence?

Case 2

- 65 year old man has emergency surgery for major abdominal catastrophe in the middle of the night
- Junior consultant surgeon calls in more senior colleague for assistance
- Senior colleague regards himself as ‘impact player’ and provides technical assistance in important part of case



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Case 2

- Junior colleague regards senior in charge and effectively relegates himself to role of registrar
- Senior colleague leaves when tricky part of the case is over leaving checking the abdomen and closure to junior colleague

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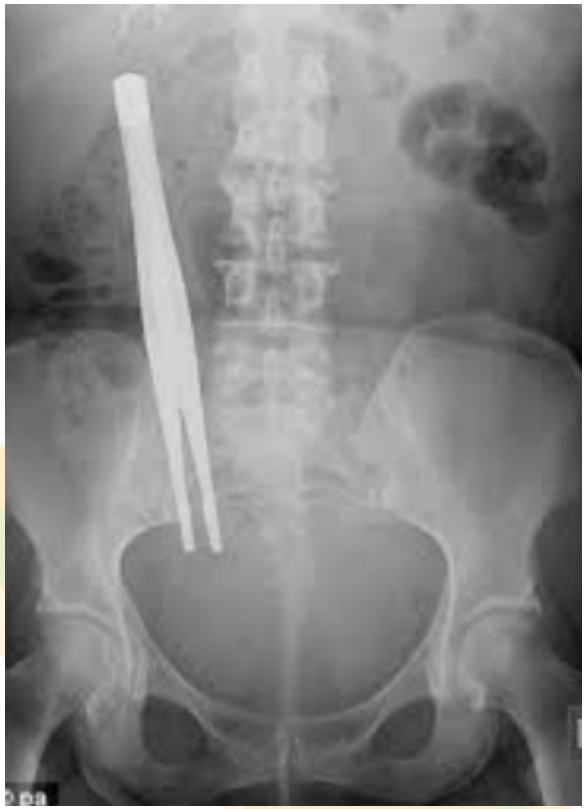
Case 2

- Junior colleague not engaged in oversight of completion of case and merely closes as a technical exercise
- Large forceps left in abdomen and not discovered until some years later



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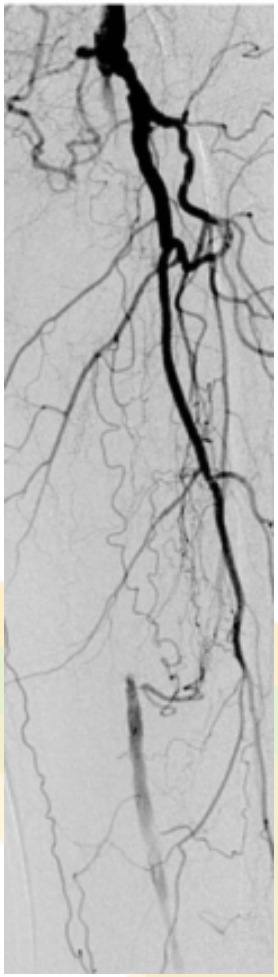
Case 2: Group task

- What systems could be improved in this case to prevent a recurrence?
- What training is available to address the apparent deficiencies?

Case 3

- 65 year old man admitted for lower extremity vascular reconstruction
- Correct leg marked but incorrect images displayed on PACS screen (different patient but impossible to see name from distance of operating room table)



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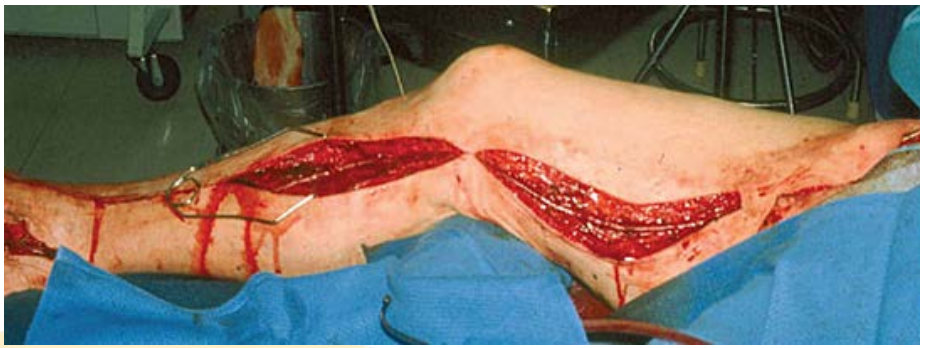
Case 3

- Surgery initiated for above knee fem-pop bypass but anatomy does not match images
- Procedure modified to femoral endarterectomy and below knee bypass
- Arm not prepared but arm vein needed to be harvested for additional length



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Case 3: Group task

- What is the underlying problem that has led to this issue?
- What solutions are available to prevent recurrence?