Title of Project: LEARNING FROM GOOD CATCHES- A NEAR MISS

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CAHO
Committed to Safer Healthcare
(An initiative of CAHO Quality Professionals Wing)

Brief Description of Near Miss

A 55 years old male was admitted with diagnosis of Bilateral Pneumonitis and was on NRBM with 6 litres of O2. Patient was advised for High Resolution CT (HRCT) Lungs.

One Nursing staff and one Ward Attendant were assigned to shift the patient. He was being shifted on stretcher trolley with O2 cylinder and Pulse Oxymeter.

Patient was wheeled out from ward at 4:15 PM and wheeled in CT Scan Department at 4:45 pm . During the transfer, patient became breathless and SpO2 dropped to 85%.

Fortunately, the patient was almost into the department and immediately he was put on centralized O2 supply of CT Scan department. O2 flow was restored without any harm to the patient.

This was a case of **near miss event**.

RCA

The analysis of incident was done using **the fish bone method.**

Man: Assigned Nursing staff was new and Ward Attendant was overconfident.

Machine: Flow Meter was faulty .

Material: Inadequately filled O2 cylinder.

Method: Delay in availability of lift, Faulty transfer protocol, no checklist for safe transfer of patient on O2, no provision for daily checking of O2 cylinder and no system of regular checking of Pressure gauge and Flow Meter.

CAPA

Correction:

Patient was immediately put on O2 through the central O2 supply in the CT Scan Department.

Corrective action:

- Training of the Staff Nurses and Ward Attendants of the concerned ward was conducted for safe transfer of patients on O2 support.
- A checklist for safe transfer of patients on O2 support was prepared and implemented.
- Provision of daily checking of Oxygen cylinder by Inventory checking nursing staff with proper SNDT.
- The protocol for calling of lift readiness was developed and lift staff were trained for due implementation.

Preventive action:

- Training of all Staff Nurses and Ward Attendant of all wards of the Hospital was done for safe transport of such patients.
- All lift personnel were trained on the protocol for lift readiness for transfer of critical patients .
- A continuous process audit was done. The successful safe transfer increased from 27% to 81% over a period of 6 months.
- Strict checking of all Pressure gauge with Flow Meters was implemented by Biomedical department at least twice a week.

Key Learning Points

- Training of Staff on departmental protocols prior to deputing them in respective department.
- Developing of lift transfer protocols for lift readiness for fast transfer of different types of critical patients
- Checking of all aspects of equipments required to transfer the critical patients prior to shifting using an checklist.
- Provision of daily checking of Oxygen cylinders by Nursing staff on duty with proper SNDT.
- Provision of regular checking of Pressure gauge with Flow Meter of all O2 cylinder g by Biomedical department personnel.

Thank You!