INTERPROFESSIONAL EDUCATION FOR QUALITY USE OF MEDICINES

Mark Green

This video was adapted from an actual clinical case in which a serious clinical error occurred and this resulted in a person's death. The coroner's report following the inquest identified the following key areas for improvement:

- Communication between staff and during handover
- Documentation and clear identification of decisions
- Use of appropriate guidelines and protocols.

PATIENT: Mark Green, 65 year-old male

HISTORY:

- No pre-existing medical conditions; non-smoker
- No family history of Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)
- Weight 75kg
- Mr Green was brought to the Emergency Department (ED) following a motor vehicle accident (MVA).
- A driver went through a stop sign and hit the side of his vehicle. Mr Green is experiencing pain in his right hip region. A small bruise is visible in that area.

INITIAL OBSERVATIONS:

- BP 130/82, HR 104 regular, RR 18, O_2 Sats 99% on room air, afebrile
- Plain X-rays of pelvis – showing fractured right neck of femur
- FBC – NAD, UEC – NAD
- Pain scale: 5-6 out of 10

Critical Thinking Questions:

Scene 1: ED

What did the orthopaedic registrar do well in this interaction?

What did the orthopaedic registrar do poorly in this interaction?

Was this a good example of informed consent? WHY/WHY NOT?

Was this an example of effective communication? WHY/WHY NOT?

At this stage is bleeding or venous thromboembolism (VTE) likely to be of greater concern?

Scene 2: Handover to ward RN

How could communication between the ED RN and ward RN have been improved?

Grand Round and Meeting:

This grand round included members of the interprofessional medication team.

Is this usual practice?

What are some of the advantages of collaborating in this way?

Who was responsible for the errors that occurred in this scenario? Should individuals who are to blame be identified?

Identify three stages in this scenario where the error could have been prevented or identified – what communication, teamwork, or leadership skills could be used in each of these stages to deal with the situation?

After meeting:

Was there a need to discuss the 'near-miss' with Mr Green and his wife?

What could the new graduate say to the patient before giving this new medication?

What actions will you take in your clinical practice as a result of what you have learned in this scenario?