Focus on patient safety

MEASURING & IMPROVING QUALITY

French Emergency Medical Aid Service

What if coordination rhymed with communication

2 July 2021

It could happen to you too

Event 1

WRONG ADDRESS LEADING TO DELAYED MANAGEMENT OF A STROKE

The daughter of a 60+-year-old patient dialled 15 after having spoken to her father on the telephone. He was saying he could no longer move his right arm and had speech difficulties. His daughter lives 30 minutes away from his home and does not have a car. The emergency dispatching physician spoke to the patient directly and concluded on a suspected cerebral vascular accident (CVA). He decided to send a response vehicle and prepared his hospital admission. Forty-five minutes after the first call, the daughter informed the emergency medical aid service that she had arrived at her father's and that no one was there. So she returned home. Two hours later, the neurologist due to admit the patient called the emergency medical aid service to say he still hadn't arrived at the hospital. The emergency dispatching physician then contacted the fire service (18) who told him the case had been closed by the control room. He then called the daughter again who told him she didn't actually enter the house when she called the second time. The patient was found dead on the response vehicle's arrival.

What happened? *Immediate cause*

Wrong address leading to delayed management of a stroke.

Why did it happen? *Root causes, barriers absent or deficient*

- The address was not entered manually in the call centre system.
- The address was not identified further to a communication failure between the 18 and 15 call centres.
- The control centre did not inform Centre 15 that the response vehicle had withdrawn further to not finding the address.
- The 15 and 18 dispatch systems were not interconnected.
- The paramedic report was not sent to the emergency medical aid service which did not react to its non-receipt in sufficient time.
- The 18 closed the case without telling the 15.
- The daughter's second call, which suggested she had entered her father's home, was what led the situation to be misinterpreted.

HAS
HAUTE AUTORITÉ DE SANTÉ

Event 2

PRIVATE AMBULANCE NOT SENT, LEADING TO INCORRECT MANAGEMENT

An 80+-year-old female patient presented with breathing difficulties. Her son called the ambulance (18). The 18 ambulance service did not send any help and transferred the call to the 15. The general practitioner dispatcher questioned the son about the mother's medical history and decided to send a private ambulance. In accordance with procedure, he attempted to contact the medical dispatch assistant several times. In light of the worsening of his mother's dyspnoea, the son contacted the 18 twice which sent a response vehicle then dialled 15 again. On assessment by the response vehicle, it was decided to transfer her to the hospital. The patient had a heart attack during the journey, 10 minutes before her arrival at the hospital, without the emergency medical aid service being informed.

What happened? *Immediate cause*

The response was late.

Why did it happen? *Root causes, barriers absent or deficient*

- Only the son was questioned. Signs of severity (difficulty speaking) were not looked for due to the lack of direct verbal contact with the patient during the first call.
- The general practitioner dispatcher was unable to reach the medical dispatch assistant rapidly, which led to the private ambulance not being sent.
- The medical dispatch assistant was not available as the emergency medical aid service was extremely busy.
- The second call to the emergency medical aid service was transferred to the general practitioner dispatcher whereas the procedure provides for dispatch by the emergency dispatching physician from the second call.
- The emergency medical aid service was not informed that the patient had had a heart attack in front of the firemen.

Event 3

MEDICAL DIAGNOSIS ERROR LEADING TO DEATH

A female patient in her twenties was treated in the hospital emergency department for high temperature and vomiting. The diagnosis was acute pyelonephritis. The patient returned home with antibiotic and analgesic treatment. The patient called the emergency medical aid service three times the next day as her symptoms had worsened. The hospital emergency medical aid service general practitioner dispatcher offered medical advice, based on the premise that the patient's symptoms were related to the adverse effects of the analgesics. The patient was admitted to the ICU where she was declared brain dead probably secondary to meningococcal meningitis.

What happened? *Immediate cause*

A medical diagnosis error led to the patient's death.

Why did it happen? *Root causes, barriers absent or deficient*

- The emergency department staff did not take account of the alert from the bacteriology laboratory.
- The patient's medical record was not consulted during the calls to number 15: emergency department admission report, results of additional tests, especially bacteriological sample, prescriptions on discharge.
- The department procedures, recommending transfer to the emergency dispatching physician from the second call for the same dispatch record, were not followed by the medical dispatch assistant.

Key words: ***Verbal and non-verbal communication – Interoperability – Team work – French emergency medical aid service***

So it doesn't happen again

Verbal communication is the main method of communication in medical dispatch. It is therefore essential to ask the right questions to enable an appropriate decision to be made and to avoid missing any important information.

There are ways of providing and disseminating reliable information such as innovative dispatch software upgrades, inter-service connections, the possibility of consulting patients' past hospital treatment records. They remain little used.

In medical response, communication is not only verbal. The safety of patients relies on team work, and it only improves when information is shared.

Focus on patient safety collection

The “Focus on patient safety” collection aims to draw the attention of and raise awareness among healthcare professionals as to risk management. Each focus covers a specific and recurrent risk based on care-related adverse events, identified and selected from national care-related serious adverse event reporting databases or doctors’ accreditation.

This focus on patient safety looks at the occurrence of adverse events incriminating a failing in communication between the various actors during medical dispatch, whether outside the hospital or within the hospital, or within the call receipt and control centre at the emergency medical aid service Centre 15.

This focus relates events with which healthcare professionals have been confronted and which are always associated with a series of dysfunctions. For this specific focus, and given the complex nature of the healthcare pathway, the events are not described in their entirety and the analyses reported focused on communication failings.

Find out more:

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