Primary care

Risks also arise

11 May 2023

It could happen to you too

Event 1

FAILURE TO MANAGE HOME BIRTH WITH LIFE-THREATENING EFFECTS FOR PATIENT

A patient in her thirties was delivering her baby at home aided by two midwife practitioners. Faced with haemorrhaging during delivery which continued despite uterine revision, the two midwife practitioners contacted emergency services. The patient was ultimately transferred to a maternity hospital by the fire services, arriving 2 hours after the birth. Her subsequent care consisted of resuming uterine revision, suturing the perineal tear, injecting iron, and conducting a blood transfusion 48 hours later.

What happened? *Immediate cause*

A failure occurred in the management of a home birth.

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

- The risk factors for haemorrhage during delivery (known fibroid) were not taken into account, in the decision to have a home birth.
- Delivery was incomplete despite the uterine revision performed at home.
- The risk to life was underestimated:
  - the patient's blood loss and severity of her clinical state were underestimated;
  - no intravenous line was fitted;
  - the emergency services were notified late and the medical information provided was incomplete: the blood loss assessment and vital signs were not provided. In the absence of this information and, hence, given the description of a falsely reassuring medical status, it was decided to request a transfer by the fire services rather than by a mobile medical unit;
  - the time to arrival at the maternity hospital proved to be too long (2 hours after the birth), in view of the amount of blood lost.

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Event 2

OVERLOOKED FALL BY PATIENT WITH ANTI-VITAMIN K OVERDOSE

A patient in her fifties with a previous history of atrial fibrillation and pulmonary embolism treated with WARFARIN had an INR (International Normalised Ratio) of 5.5. When notified of this overdose, her primary care physician notified the nurse, who went to the patient's home to change her pill organiser by removing WARFARIN. The nurse discovered that the pill organiser was empty. The INR returned to normal, but 11 days later, the patient presented with confusion and ataxia. The patient was urgently admitted to hospital and a chronic left subdural haematoma was detected, requiring surgical drainage.

What happened? *Immediate cause*

A fall by a patient subject to an anti-vitamin K overdose went unnoticed.

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

- The patient had not undergone a cognitive assessment, and therefore had not been monitored regularly as to whether she was taking her treatment correctly: nurse practitioners visited her twice weekly to prepare her pill organiser, but they did not manage medication administration.
- There had been no fall risk assessment, and, hence, no prevention of such a risk for this patient on anticoagulant medication.
- A known context of alcoholism was not taken into account.
- Two days' worth of medication were not in the pill organiser and the patient was unable to provide an explanation.
- The family had not reported the fall that occurred a few days earlier.

Event 3

FAILURE TO DIAGNOSE HYPOGLYCAEMIA IN DIABETIC PATIENT RESULTING IN HER DEATH

A patient in her seventies with multiple comorbidities and living at home with her son was attended to by a junior locum private nurse practitioner. On the morning after the locum cover, the nurse practitioner found the patient asleep with a low blood sugar level of 0.51 g/L. She notified the patient's son who said that she was often drowsy. She tested the blood sugar again 5 min later and obtained a value of 0.67 g/L. She consulted the blood sugar log for the previous days, which showed the results to be in order. She did not wake the patient, but, somewhat concerned, called the patient's son during the day, but did not get through. The following day, when she called at the patient's home, she found the patient dead.

What happened? *Immediate cause*

Failure to manage hypoglycaemia appropriately in a diabetic patient.

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

- The nurse did not carry out appropriate monitoring (repeated capillary blood glucose follow-up) of this vulnerable elderly patient.
- Glucose was not administered despite symptomatic hypoglycaemia.
- The nurse practitioner was a locum, and inexperienced in private practice, and did not receive guidance from the other more experienced nurse practitioners in the practice.
- The close family were falsely reassuring.
- The locum nurse practitioner was in a state of chronic fatigue, in her work and home life, as she had been kept awake the previous nights by her 2-year old child.

Keywords: ***primary-primary/primary-hospital care coordination – diagnostic error – assessment – home care***

So it doesn't happen again

A review of serious adverse events using the national care-related adverse event reporting database highlighted 209 primary care-related serious adverse events from March 2017 to December 2021.

Most of these pertain to hospitalisation at home (HAH), emergency service call handling failures or suicides in patients on leave from psychiatric care.

Although hospitalisation at home does not legally fall under primary care, it is generally run using professionals (doctors, nurses, pharmacists, pathologists), which explains why it is encountered when looking at primary care.

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To promote continuity of primary care and facilitate primary-hospital care coordination, the management of care-related serious adverse events is based on:

- **information sharing** between all the professionals involved in the care pathway, as well as the patient and their family circle. A number of tools are available to professionals:
  - discharge letters,
  - secure messaging systems, shared medical record,
  - alert procedures between pathology laboratories and the primary care physician, and relevant healthcare professionals, particularly regarding pathology monitoring of patients on anticoagulants,
  - new coordinated work methods, such as regional healthcare professional communities, multidisciplinary health centres,
  - team-based development of a personalised care plan and sharing of the patient's status;
- **assessment of the capability of the most vulnerable patients to remain at home**;
- **implementation of national best practice recommendations** for home births:
  - which must only be envisaged if the pregnancy is normal,
  - which must not pose an increased risk of complications.

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 serious adverse events, identified and selected from national care-related serious adverse event reporting databases or doctors' accreditation.

This Focus on patient safety focuses on serious adverse events related to primary care, which, like all care sectors, is exposed to risk management and communication failure issues.

This guide relates events with which healthcare professionals have been confronted and which are always associated with a series of dysfunctions.

Find out more

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