Case Example #1
A death resulting from failure to rescue

A patient underwent surgery at a hospital. The procedure and post-op recovery were uneventful and the patient remained on cardiac monitoring during recovery on a medical unit.

Morning of post-op day 1: The monitor in the telemetry room showed an abnormal rhythm suggesting the leads were off, once again. Per protocol, the technician called the corresponding nurse but was unable to reach the nurse. The patient went from sinus tachycardia to ventricular tachycardia.

At this time, the telemetry technician within the monitoring room is responding to another patient's concern regarding rhythm and forgets to call the nurse after 5 minutes had elapsed, per policy. Though the monitoring room is normally staffed with two technicians to monitor 120 patients on average, only one telemetry technician is in the room; the other technician is on a unit retrieving a used telemetry monitor to clean and inventory.

27 minutes later, while performing routine rounds, the nurse entered the room to find the patient unresponsive. A code is called. The responding charge nurse immediately retrieves the crash cart as the nurse begins compressions.

3 minutes later, the code team arrives. The certified registered nurse anesthetist (CRNA) requests supplies for intubation and the nurse provides an endotracheal tube but it is pediatric in size. The CRNA manually ventilates the patient as an adult endotracheal tube is located from a crash cart on another floor. By this time, more personnel are responding to the code.

7 minutes later, the defibrillator is turned on after confusion with defibrillator status. Pads are placed on the patient and the first rhythm strip is recorded.

6 minutes later, after being defibrillated, the patient decompensates further.

21 minutes later, after efforts to resuscitate, the patient expires.

The team conducted a post-code huddle/debriefing in which they identified risks and opportunities to improve their rapid response.

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SAFETY STRATEGIES

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FOOTNOTES


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