Alexandria Patient Safety Alliance

For Safer Practice

Sixty Patient Safety Stories

True Safety Incidents

This resource booklet contains 60 true patient safety incident as reported voluntarily by healthcare professionals from various healthcare institutions and sectors. The stories in the booklet are suitable to use with patient safety awareness programs. Furthermore, the stories could be used for training on significant event audit, root cause analysis, and control analysis.

2017

Resource Booklet

Patient Safety Stories – Five Years of True Stories

Year One	Year Two
1 Medication safety 2 Medication safety 3 Blood Safety 4 Tube Misconnection 5 Wrong patients 6 Retained Instrument 7 Patient fall 8 Wrong drug / identification 9 Missing equipment 10 Medication safety 11 Wrong patient 12 Patient fall	13 Wrong Patient / Blood 14 Missed complication 15 Translocation error 16 Instrument Failure 17 Wrong route 18 Equipment failure 19 Wrong hospital 20 Multiple incidents 21 Wrong family 22 Pressure ulcer 23 Medication Safety 24 Retained surgical swab
Year Three	**Year Four**
25 Misconnection 26 Missed Diagnosis 27 Iatrogenic injuries 28 Wrong Route 29 Near Miss 30 Failure to report 31 Patient fall 32 Missed Diagnosis 33 Wrong pathway 34 Lost Time 35 Locked-up. 36 Unprofessional.	37 Diagnostic error 38 Medication reuse 39 Retained gauze 40 Injection safety 41 Faulty connection 42 Unclassified 43 Extremes 44 HAM 45 Faulty discharge 46 Medication safety (Sound Alike) 47 Wrong surgery 48 Wrong patient
Year Five	
49 Missing equipment 50 Miscommunication 51 Dangerous reuse 52 Faulty equipment 53 Missing labels 54 Medication safety 55 Prescription error 56 Again 57 Silent instrument 58 Three names 59 Faulty investigations 60 Cognitive dissonance	

1. Medication safety

Two qualified doctors were attending a three day training course away from their home town. On the second day of the course one of the doctors suffered from acute gastroenteritis (nausea and vomiting) most probably from a meal he ate in one of the fast food chains during the first day of the course. The sick doctor asked his colleague to help him administer an intravenous anti-emetic drug because he was feeling sick and did not want to start vomiting. His colleague went to the nearest pharmacy and bought the drug and necessary equipment. After injecting his colleague with the drug, it was discovered that the drug that was administrated was not the required anti-emetic drug but a non-steroidal anti-inflammatory drug.

2. Medication safety

An anesthetist during work asked his colleague to give him an IV antibiotic because he was starting to suffer from a sore throat. His colleague agreed and an IV catheter was inserted in his forearm and the antibiotic prepared (diluted). However, as soon as the antibiotic was being injected the anesthetist started to scream from severe pain. His colleague thought that the catheter was misplaced and the antibiotic was being administered subcutaneously. However, the catheter was found to be properly placed and when the situation was further investigated it became apparent that the antibiotic was diluted using potassium chloride.

3. Blood Safety

I am a nurse. One of my relatives with known leukemia was in hospital suffering from general fatigue. His sister contacted me to urgently join her in the hospital because there were no free nurses to help her. I rushed to the hospital and asked the nurse available how I could help. She told me that I could help in transfusing a pack of blood that was ordered for my relative. I took the blood pack from the nurse and hung it on the holder beside my relative in preparation to attach the transfusion set.

Suddenly, I noticed that the blood group written on the blood pack label was not my relative's blood group, which I knew before hand. I checked the name on the blood pack label and discovered that it was similar to my relative's first and second name but different in the rest.

I hurried to the nurse to inform her and she contacted the blood bank personnel who confirmed that the pack belongs to another patient and that my relative's blood pack was still in the blood bank.

4. Tube Misconnection

A patient who underwent an abdominal operation had a central venous line inserted into his left internal jugular vein and an epidural catheter inserted for pain control with bupivacaine via a syringe pump. The epidural catheter was fixed to the patient's back over his left shoulder with adhesive plaster.

Hospital policy was to keep patients with epidural catheters in the recovery area until the epidural catheter was removed. Due to staff shortage patients were discharged to their wards at the end of the morning shift. Not all ward staff had received training on handling epidural catheters with syringe pumps.

The patient was discharged to his ward with both central and epidural catheters in place. A senior nurse during her ward round later that day discovered that the syringe pump with bupivacaine had been connected the central venous catheter and not to the epidural catheter. Luckily the patient did not suffer from any adverse events.

5. Wrong patients

A patient was scheduled to have a cholecystectomy because of gall stone disease. The patient arrived late to the hospital. Meanwhile, another patient with gall stone disease appeared at the hospital operating theatre to consult with his surgeon about his future cholecystectomy. The staff in the hospital who at the time were looking for the first patient took the second patient into the operating room and a cholecystectomy was performed. When the first patient arrived late at the operating room, the staff recognized that they had operated on the wrong person but luckily it was the right operation!

6. Retained Instrument

An obese patient was operated upon to repair his abdominal incisional hernia using an onlay mesh. On the first post-operative day, the surgeon noticed that the suction drain was not yielding any discharge and the patient was suffering from abdominal pain. The surgeon revising the operative steps in his mind recalled clamping the suction drain from inside the abdomen to ensure proper placement of the suction drain but did not recall removing the clamp by himself although the operating nurse confirmed right count of the instruments at the end of the operation. The patient was taken to the radiology room, where an abdominal X-ray revealed a retained clamp. The patient was taken to the operating room to remove the clamp which was found clamped to the suction drain in the subcutaneous space. The patient recovered with no complications. It was found later, that there was a change in the operating nurse during surgery.

7. Patient fall

A patient was sent to the recovery unit after undergoing a splenectomy. As all beds in the recovery area were occupied the patient was kept under observation on a trolley in the recovery unit. The patient had a Foley's catheter which was attached to a collecting system that was attached to the side of the trolley. Unfortunately the patient fell from the trolley as it had no side rails and the catheter was forcefully extracted from the urinary bladder. The patient suffered from hematuria, however, further investigation revealed an intact urethra and a new Foley's catheter was later inserted till the hematuria resolved. The patient had an uncomplicated recovery from his surgery.

8. Wrong medication / wrong identification

I'm a doctor and so is my husband. He suffered from acute appendicitis and was admitted to hospital and an appendicectomy was performed immediately.

He was then transferred to his ward room where he complained that the Air Conditioner was not working properly and asked to be transferred to another room which was done. After two days he noticed that he was taking three types of medications. One, he assumed, would be an antibiotic, the other probably an analgesic, but he wondered what would the third one be? He decided to inquire and it turned out that the third medication (to our surprise) was related to treatment of prostatic hyperplasia.

When he further inquired about the reason for being prescribed such a drug for a young man, he found out that this drug was intended for the former patient residing in this room who was moved to another room. It became clear that the hospital uses room numbers as part of their policy for patient identification.

9. Missing equipment

A patient was scheduled to undergo a therapeutic endoscopy (ERCP) to remove a stone from the bile duct. The endoscopist nurse responsible for the procedure arrived at the unit and noticed that an endoscope was in the disinfecting machine and assumed that it was the duodenoscope required for that procedure. The patient arrived at the hospital as scheduled and was taken to the operating room and given an anesthetic.

When the endoscopist nurse removed the endoscope from the disinfecting machine she discovered that it was a colonoscope that had been used earlier on. When she went to look for the duodenoscope she discovered that it was not available in the unit.

It was found out that the duodenoscope had been lent to another hospital earlier this day and was on its way back to the hospital. One and half hour later the duodenoscope arrived at the hospital and the procedure was then performed.

10. Medication safety

An inpatient with difficulty of breathing was to receive some form of inhalation medication through a respiratory nebulizer. Nurse in charge, while preparing the necessary medication, was called to attend to another distressed patient leaving the primed syringe with inhalation medication in the medication cart. While attending the distressed patient, the nurse asked her colleague to give the patient with difficulty in breathing a diuretic which was also prescribed for him. The nurse went to the medication cart and found the primed syringe and injected it into the patient intravenously thinking it was primed with the diuretic. The two nurses discovered the medication error at the end of the shift while they were revising the medication cart. The patient did not suffer from any complications.

11. Wrong patient

A surgeon working in an endoscopy unit scheduled a patient for a hernia surgery and told him to meet him at the endoscopy unit on the morning of the surgery. The patient arrived at the unit and was told to wait at the reception area. The patient noticed that several other

patients in the reception area were being taken care of while he was left with no progress. He volunteered to one of the auxiliary staff that he was here to be taken care of and not to be neglected while other people are being taken care for. The auxiliary staff seeing that the patient was right, in being left for a long time, took him to the endoscopy procedure room. He asked him to change his clothes in preparation to undergo an endoscopy when the patient volunteered that he came to the hospital to undergo a hernia surgery.

12. Patient fall

A patient had a minor operation in the left lateral position under rapid intravenous anesthesia. The patient was left to recover in this position. During his recovery the patient unconsciously changed his position into the supine position resulting in his fall from the operating table onto the floor. As it was difficult at the time to assess whether the patient suffered from concussion as a result of the fall it was decided to keep the patient under observation in the hospital for 24 hours. When reviewing the adverse event it was clear that all members of the healthcare team in the operating room had left the patient to recover under no close observation.

13. Wrong Patient and Wrong Blood

A newly appointed nurse was responsible for transfusing a unit of blood to one of her patients during an afternoon shift. The nurse in preparation of the blood for transfusion asked a relative to the patient to warm the blood by keeping it close to her body. The relative, of medical background, noticed that the name of the patient on the blood unit pack was different from the name of her relative patient. The relative immediately notified the nurse who revised the data on the blood pack to notice that the blood unit pack label has dedicated space for two names; one for the patient and the other for the blood donor. Furthermore, she discovered that not only was she going to transfuse the blood to the wrong patient but also that she had misread the donor’s name on the blood pack as the patient’s name. The first two names of the concerned patient in this story were similar to the first two names of the blood donor on the blood pack.

14. Missed complication

A patient underwent a therapeutic endoscopy through the oral cavity (ERCP) under rapid acting intravenous anesthesia. The procedure was successful and the patient was discharged and given a follow-up appointment after one week. At the follow-up visit the patient complained of pain in her jaw with limited movement and inability to completely close her mouth which affected her ability to eat and drink during that week. Examination of the patent revealed that she was suffering from jaw dislocation which was not diagnosed at time of discharge the previous week. The patient was referred to a specialist unit where her jaw was reduced into its proper place.

15. Translocation error

A patient who was admitted to hospital had a chest X-ray. The X-ray revealed multiple lung consolidations (pneumonia). The doctor in charge initiated a course of antibiotics and ordered a CT chest for the patient. To his surprise the CT chest revealed normal lung fields.

When reviewing the chest X-ray report and film it was realized that the name on the chest X-report was correct while the name on the X-ray film was wrong and belonged to another patient who was actually suffering from pneumonia. After several inquiries, it became clear that the X-ray films were put into their folders and incorrectly named which resulted in the X-ray reports being incorrectly named. Meanwhile, the diagnosis and treatment of the patient with pneumonia was delayed as he, due to the X-ray mix, was wrongly diagnosed to have clear lung fields.

16. Instrument Failure

A 60 years old male patient with end stage renal disease on maintenance hemodialysis, developed difficulty in breathing and chest discomfort two and a half hours after his mid-week dialysis session , and was found to have hypotension. He had experienced no problems during his previous dialyses with the same dialyzer and circuit, and had been hemodynamically stable prior to starting dialysis. The machine conductivity was within the normal range and no alarm was triggered.

At the time of this event he was found to be acidotic and hyperkalemic. He was admitted to ICU, treated with a dopamine drip and sodium bicarbonate infusion. After hemodynammic stabilization a hemodialysis session, using bicarbonate buffer and another machine, was conducted. All the metabolic abnormalities were reversed and the patient was discharged in stable condition

The bicarbonate inlet line of the machine was subsequently found to be blocked by deposits of bicarbonate.

17. Wrong route

A nurse during a buzzy shift asked the ward oderly to help her distribute the shift medication to the ward patients. One of the patients was prescribed an antibiotic suppository. This patient after a while appeared at the nursing station complaining of difficulty in swallowing as the medication given to him was stuck in his throat. It appeared that the patient had swallowed the suppository thinking it was meant to be taken orally instead of rectally.

18. Equipment failure

A patient was undergoing a scheduled balloon dilatation of a benign biliary stricture. After successful dilatation of the stricture the endoscopist was unable to remove the balloon from the patient (biliary tree) although the nurse endoscopist deflated the balloon. Faced with this situation, the endoscopist tried to remove the balloon with the help of a stone crusher thinking that it would burst the balloon making it possible to remove it. However, the attempt failed resulting in breakage of the catheter with the distal part containing the balloon and two thirds of the catheter stuck to the biliary tree. The endoscopist was able to insert a biliary stent beside the stuck balloon catheter thus ensuring biliary drainage. The endoscopist decided to stop at this stage and when the patient recovered from the anesthetic he explained to him what had happened and recommended a wait-and-see policy to which the distressed patient agreed. One month later, the patient informed the endoscopist that he had passed the balloon catheter while defecating.

19. Wrong hospital

A patient arrived at an endoscopy unit to undergo endoscopic examination of the upper gastrointestinal tract. The receptionist could not find his name in the unit registry. After questioning his accompanying nurse, it was discovered that the patient was an inpatient from another hospital and was scheduled to have an endoscopic examination in that hospital but by mistake was taken to an endoscopy unit of another hospital.

20. Multiple incidents

A patient suffered from a perforation in his duodenum while undergoing a therapeutic endoscopic procedure. The patient was operated upon and then admitted to the ICU. During his stay he developed several infections. He started to receive a combination antibiotic intravenously every 12 hours based on the culture and sensitivity results done. While receiving his fifth injection the patient suffered from sudden onset of cardiac arrhythmia leading to cardiac arrest and death.

21. Talking to the wrong family

A surgeon was performing a cholecystectomy on two successive patients during his morning operative session. The first turned out to have a malignant tumor while the second had gallstones. Between the two operations the surgeon informed the family of the first patient about the unexpected findings. Before leaving the hospital, the surgeons visited the two patients in their rooms. He started with the second patient and was surprised to find his family in a state of shock. He immediately realized that he had informed the wrong family about the unexpected malignant tumor!

22. Pressure ulcer

A patient was admitted to hospital suffering from hematemesis. The managing team diagnosed him with bleeding oesophageal varices. A Sengstaken-Blackemore (SB) tube was inserted and inflated to control the bleeding. Forty eight hours afterwards he was scheduled for an upper gastrointestinal endoscopy. Prior to endoscopy the SB tube was deflated, the anchoring adhesive plaster removed from the patient's nose, and the tube extracted revealing a severely ulcerated tip of the nose with areas of necrosis.

23. Medication Safety

An inpatient was receiving a low molecular weight heparin (LMWH) injection every 12 hours. The ward nurse administered his morning dose at the appropriate time when she was informed by the patient that the evening shift nurse had administered a similar injection just before the end of the evening shift. The ward nurse checked the medication charts which showed that the patient was receiving a 12 hourly injection of LMWH and had received his evening dose at the appropriate time. To clear this conflict, the ward nurse contacted the evening shift nurse (later) who revealed that she had forgotten to give the patient his evening dose and when she remembered (at the end of her shift) she administered the injection before leaving the ward.

24. Retained surgical swab

A young boy presented to the emergency department with an acute abdomen. He was urgently operated upon revealing generalized peritonitis secondary to a perforated appendix. The appendix was removed and the peritoneal cavity lavaged. He had a smooth postoperative course and was discharged from the hospital within a week. A few months later he presented again to the emergency department with high fever, abdominal distension and raised white blood cell count. Clinical and radiological assessment pointed towards the diagnosis of a pelvic abscess. He was urgently operated upon to reveal a large concealed pelvic abscess with a retained swab in the pelvis from the previous exploration.

25. Misconnection

A patient underwent a surgical resection of a segment of the jejunum. The distal end of the anastomosis was used to create a feeding jejunostomy. The patient had two tube drains one connected to the feeding jejunostomy and the other to the peritoneal cavity. Instruction were given to start enteral feeding. During a routine round on the patient it was discovered that the feeding was initiated through the tube drain connected to the peritoneal cavity and not the tube connected to the feeding jejunostomy.

26. Missed Diagnosis

A young boy was admitted to hospital because of inability to swallow, regurge / vomiting and dehydration. He was given IV fluids and his chest and abdomen X-rayed. The X-rays were unremarkable except for the presence of a zipper handle on the chest X-ray, which was attributed at the time to the clothes that he was wearing while being X-rayed. The boy was discharged with no definitive diagnosis, however, after several days he was readmitted with the same complaint. The same procedures were repeated and the chest X-ray, again, revealed the zipper handle. Reviewing the old X-rays and the boys clothes; it was immediately realized that the boy had swallowed the zipper handle. An upper endoscopy was performed confirming the diagnosis and the zipper handle was removed safely.

27. Iatrogenic injuries

A patient required urinary bladder cauterization before surgery. The resident requested the nursing team to prepare the necessary equipment so he could insert the urinary catheter. When he arrived at the ward he found that a nurse trainee had inserted the urinary catheter, however, the patient was in pain. The resident, who was also in his induction period, re-inserted the urinary catheter. After surgery, it was noticed that no urine was present in the collection bag. The catheter was removed and a significant amount of blood came out of the urethra. It was then realized that the patient had suffered from an iatrogenic injury of the urethra earlier in the ward.

28. Wrong Route

A nurse asked a hospital worker to help her administer medication to some of her patients. She gave the worker an antibiotic suppository and told him to give it to one of her patients.

After some time, the patent appeared at the nursing station stating that since he swallowed the medication he feels that it is stuck in his chest (oesophagus)!

29. Near Miss

Two patients with the same diagnosis of piles were admitted to hospital into the same room. One patient had his surgery on the day of admission while the other was scheduled for the next day. The nurse in charge during the night shift asked the ward orderly to administer an enema to the patient awaiting his surgery. She informed the orderly that the patient was laying on the bed near the window. The orderly went to the patient and informed him that he was to administer him an enema. The patient, although astonished, complied and the orderly discovered that he was going to administer the enema to the wrong patient. It appeared later that the two patients has swapped their beds for comfort reasons.

30. Failure to report

A newly qualified nurse was working under the supervision of a senior nurse. The senior nurse asked the new nurse to administer insulin to the diabetic patients in the ward. The new nurse asked the senior nurse, who was talking on her mobile, whether to administer the whole syringe or not. The senior nurse replied positively to that question. So the new nurse administered the whole syringe primed with long acting insulin (100 units) to two patients. When approaching the third patient; it was commented by a relative that he usually does not take a whole syringe of long-acting insulin. The new nurse with the patient's relative consulted the senior nurse and it was discovered that the patient's relative was right and that the new nurse had given high doses of long acting insulin to the previous two patients. Faced with this situation, the two nurses decided not to report the incident and instructed the two patients to consume large amount of sugar hoping that this will control the situation. At the end of their shift they informed the night shift nurse about the situation. The night shift nurse did not report the incident and performed frequent blood sugar analysis to the two patients. At the early hours of the morning the two patients started to suffer from signs of hypoglycemia when their blood sugar levels fell to 20 and 30 mg / dl. At this time the night shift nurse decided to report the incident to the resident on duty. The patients were given IV glucose 25% and the situation was then controlled.

31. Patient fall

A patient with a history of previous falls was admitted to hospital. The patient woke up in the early hours of the morning to go to the bathroom. On his way out of the bathroom he fell and hit his head. One of the other patient's relatives in the ward heard him fall and called for help. As a result of the fall the patient suffered from a fissure fracture of the skull, multiple hematomas and bruises. The injuries did not require intervention. The patient had difficult relations with his family and that is why he was on his own in the hospital.

32. Missed Diagnosis

An eight month old baby girl started to complain of chest infection. She had a plain x-ray which did not reveal any significant radiologic features. She was admitted to hospital for 11 days to treat her chest infection. The problem persisted after discharge and a second chest

x-ray was performed. A safety pin was seen on the X-ray film and was claimed to be used for fixing her dummy to her clothes. However, the radiologist noticed that the safety pin was open. By examining the baby girl no safety pin was found. The old X-ray was reviewed and the same open safety pin was seen. It was then realized that the baby girl had swallowed the safety pin a while ago. An endoscopy was performed and the safety pin was removed from the oesophagus.

33. Wrong pathway

An insured patient with advanced hepatic cirrhosis, ascites and an obstructed para-umbilical hernia was admitted to a medical ward at 12:00 noon. At 13:00, surgical consultation was requested. A surgical resident within the next hour evaluated the patient and contacted his senior consultant at 14:00. By that time no consultants were available at the hospital to promptly evaluate the patient. At 17:00 the senior consultant examined the patient and decided that the patient was suffering from a strangulated hernia and is in need of an urgent surgery. The patient was operated upon at 22:00 when blood and plasma became available as requested by the on duty consultant surgeon. At surgery a gangrenous intestinal loop was found in the hernia necessitating resection anastomosis.

34. Lost Time

At 10 PM a lady was admitted to the outpatient of a hospital suffering from acute pain in her right leg. The doctor examined her and found that she was suffering from acute ischemia in her right lower limb. The doctor asked her to go to the X-ray department to have a Doppler examination of her lower limbs which he documented in the X-ray request but without writing the clinical diagnosis.

The lady went to the X-ray department and was given an appointment after 24 hours. The lady returned to the doctor who contacted the X-ray department to inform them of the urgency of the investigation. The X-ray department technician agreed and she had the investigation performed by the department doctor at 1 PM which showed occlusion of the arteries of her right leg and foot. The X-ray doctor informed the patient's escorts the results of the investigation without explaining the critical nature of the situation. The patient's escort informed the outpatient doctor about the diagnosis who ordered an immediate CT angiography on both lower limbs. The patient returned to the X-ray department to have the CT angiography done after doing a blood analysis for urea and createnine levels. The CT angiography was performed at 3 PM and the patient received the CT films without a report at 5:30 PM.

The patient was advised to go to another hospital as there was no vascular surgery in the hospital where she was diagnosed. She went to the new hospital, however, it appeared to be a wrong hospital. She then went to the right hospital and appeared at the emergency department where she was admitted at 7 PM. She started to receive specific treatment for the ischemia at 11 AM when she was examined by the hospital consultant.

35. Locked-up.

An endoscopy unit was getting towards the end of their working day. While the last patient was recovering from the endoscopic examination the unit staff started to close the unit. The staff member responsible to shut the unit checked on the patient in the recovery area and told him that it was time to leave the unit. The patient supported by his wife left the recovery area after which the staff member shut the unit. A few hours later the hospital security heard loud shouting from inside the unit. The security, with their emergency keys, opened the unit to discover that the patient and his wife were locked inside the unit. It transpired that the patient and his wife on their way out from the unit went to the toilet area without being noticed which resulted in them being locked in the endoscopy unit for several hours.

36. Unprofessional.

A women in a public hospital was referred to the radiology department to undergo an abdominal ultrasound free of charge. She was given an appointment after 24 hours and was instructed to take anti-flatulence medication till the examination. Her husband, on his own initiative, also requested to have an abdominal ultrasound on his own expense. To his surprise he was given an immediate appointment without any preparation.

37. Diagnostic Error.

A lady had a fine needle aspiration (FNA) from a lump in one of her breasts. The result of the FNA stated the presence of malignant cells in the aspirate. As a result, she had a mastectomy. The final pathological examination of the removed breast did not reveal any malignancy.

38. Medication Reuse.

A patient suffered from severe shivering after endoscopy. When revealing possible causes it was discovered that opened propofol ampoules were kept in the fridge for reuse.

39. Retained Gauze.

A patient underwent excision of the thyroid gland for a multinodular goiter. The patient was discharged after a smooth postoperative period. However, the patient complained of the persistence of the swelling on one side of the neck. The patient was diagnosed with incomplete removal of the gland and underwent a second surgery. During the redo surgery it was discovered that the swelling was a small piece of gauze that had been retained in the thyroid gland bed during the first surgery.

40. Injection Safety.

A healthcare provider was given the task to administer insulin to all diabetic patients in a ward. Protocol states bedside estimation of blood glucose level before administrating the appropriate dose of insulin. Faced with this task and with shortage of blood sampling needles, the healthcare provider used each patient's insulin syringe needle to obtain the

required blood sample and also to withdraw the appropriate dose of insulin from the ward insulin vial.

41. Faulty Connection.

A urinary catheter was inserted to a patient as part of the required care. Staff noticed that the patient was not producing any urine as evident by lack of urine in the collecting bag. A urologist was consulted who confirmed the proper position of the urinary catheter. Staff in charge started to give the patient fluids and medication in an attempt to push the kidneys to produce urine but with no result. Patient was then diagnosed with acute renal failure and blood withdrawn to confirm the diagnosis and steps were taken to schedule the patient for hemodialysis. During the course of events the patient was complaining of lower abdominal pain and ultimately the patient involuntarily passed stools. During patient cleansing from resultant soiling the urinary catheter was disconnected from the collecting system resulting in the free flow of a large amount of urine. It became apparent that the collecting system was blocked because it was connected to the urinary catheter with its cap on!

42. Unclassified.

A surgeon electively prepared a patient for surgery based on an orally reported CT examination. The patient was anesthetized and the assistant surgeon opened the patient while the surgeon was reviewing the digital images of the CT examination. The surgeon discovered that the digital images do not fit with the oral report that he previously received. Faced with this problem, the operating team had to wait for two hours while the right digital images were sent from the radiology center before they could resume the surgery.

43. Extremes.

A patient on large dose corticosteroids developed deep vein thrombosis. She was admitted as an emergency case to a public hospital around noon time. Five hours later she had not been seen by any doctor. Her family asked the nurse in charge about the expected time the doctor was going to see her. They were surprised to know that the doctor was going to see her next morning. Faced with this level of care they asked to be discharged and went to a private hospital where she was immediately admitted to the intensive care unit!

44. HAM.

A patient undergoing a major surgery suddenly developed cardiac arrest. After successfully resuscitating the patient and completing the surgery, the surgical team in attempt to understand what went wrong discovered an open and empty ampoule of potassium chloride. The team came to the conclusion that the ampoule must have been mistaken for distilled water when preparing medication for the patient.

45. Faulty Discharge.

An elderly patient underwent endoscopic esophageal stenting. A sealed scalpel blade was used to mark the stricture level by fixing it to the patient's back with adhesive plaster. The patient was discharged after the procedure, however, he complained of back pain and

contacted his doctor who advised him to have an X-ray on his chest. The x-ray report stated that a surgical scalpel blade was retained within the patient's chest. The patient alarmed by the diagnosis contacted his doctor who advised him to see him immediately. The doctor checked the patient's back to discover that the surgical scalpel blade was still attached to his back. The doctor removed the surgical scalpel blade and assured the surprised patient that everything was alright.

46. Medication Safety (Sound-Alike).

A patient was prescribed an intravenous amino acid: Dipeptiven as part of his postoperative treatment. Dipeptiven, at the time, was not available at the hospital pharmacy. The patient family ordered the medication from a friend pharmacist through the mobile. The pharmacist dispensed a hypnotic: Deprivan (sound-alike) instead of Dipeptiven. Unfortunately, the wrong medication was given to the patient leading to acute respiratory failure and ICU admission.

47. Wrong Surgery.

A surgeon scheduled two of his patients to undergo surgery. One patient was scheduled for tonsillectomy while the other was scheduled for an ear surgery. After he completed the two surgeries and while writing the operative notes he discovered that he had performed the ear surgery instead of the tonsil surgery and vice versa.

48. Wrong Patient.

Two patients with the same diagnosis were scheduled for surgery on the same day and same time. They were anesthetized by the same anesthetist. They were operated by two different surgeons. After surgery and while documenting their operative notes each surgeon discovered that he had operated on his colleagues patient. Luckily it was the right surgery.

49. Missing Equipment

A patient developed dyspnea during a prolonged postoperative period. The patient was put on oxygen and a CT examination of the chest and abdomen was requested by the managing doctors. The patient was taken to the radiology department to have the CT examination. The radiology technician faced with a dyspneic patient and no oxygen, requested that an oxygen cylinder be brought to the patient first. An oxygen cylinder was delivered, however, it turned to be empty. A second oxygen cylinder was delivered which was full, however, no tools were available to connect the cylinder to the oxygen delivery system. By that time the patient became cyanosed and suffered from cardiac arrest.

50. Miscommunication

A middle aged lady went to the emergency room of a hospital with a broken patella. She was operated on by the on-call orthopedic surgeon. A week later she had her stitches removed and was asked to come back after one month to check the healing of her fracture. During that visit she complaint to the orthopedic surgeon that she could barely bend her knee. The

orthopedic surgeon asked her if she was getting physiotherapy. Surprised, she replied that nobody advised her to have physiotherapy.

The orthopedic surgeon had been practicing for a long time in Europe and recently came back to practice in Egypt.

51. Dangerous Reuse

A patient required an enema before surgery. The patient immediately suffered from severe generalized abdominal pain. The enema was stopped and the event investigated. It was found that the hospital, due to water shortage, had stored water in various jerkins and the one used for the enema still had large amounts of a disinfectant (gluteraldehyde).

52. Faulty Equipment

A doctor faced with a shocked bleeding patient in an established private hospital asked for a sphygmomanometer to measure the patient's blood pressure. A sphygmomanometer was delivered and while measuring the patient blood pressure he noticed that the apparatus was broken. Another sphygmomanometer was delivered and again the doctor noticed that the new apparatus was not working. A third sphygmomanometer was delivered and this time it was working. All this witnessed by the the patient and family. Precious time and trust had been lost.

53. Missing Labels

A patient was undergoing an invasive procedure to obtain a biopsy. The specimen was sent to the pathology lab where it was discovered that it was damaged because chlorine instead of formaldehyde was used for its preservation. Incident analysis revealed that the formaldehyde bottle was not labelled and when empty was filled with chlorine to clean the floor by one staff. Another staff took the chlorine filled bottle back to its original place thinking it was filled with formaldehyde.

54. Medication safety

A boy was undergoing circumcision under local penile anesthetic block and inhalation anesthesia. During the procedure the boy suffered from apnea requiring intubation and transfer to the ICU. It was discovered afterwards that a muscle relaxant was used instead of a local anesthetic for the penile block.

55. Prescription Error

A women was suffering from morning sickness early in her first pregnancy. Her managing obstetrician prescribed her three types of mediation; folic acid, omega 3, tamoxifen. When her morning sickness persisted she reviewed the prescribed medication and discovered that the third drug was not for morning sickness but an estrogen receptor modulator with a risk pregnancy category D.

56. Again

A patient who had an endoscopy phoned her doctor complaining of abdominal pain. Her doctor advised her to take two tablets of the antispasmodic analgesic buscupan compositum. She went to a community pharmacy where she was given an

alternative medication. She sent a photo of the alternative medication to her doctor over WhatsApp. To the astonishment of her doctor the prescribed medication was tamoxifen an estrogen receptor modulator with a risk pregnancy category D.

57. Silent Instrument

A patient who had a cholecystectomy five years earlier suffered from hepatitis C. His course was complicated with liver cirrhosis and hypersplenism to which he was advised to surgically remove the spleen. As part of his pre-operative work-up he had a plain X-ray chest that revealed, to the surprise of everyone, a retained surgical instrument from his previous cholecystectomy!

58. Three Names

A doctor reviewing a patient's medical records noticed that she had been identified by three different first names; on occasions she was named Nadia, in others Fadia, and sometimes even Shadia.

59. Faulty Investigations

A young girl (14 years) complains of abdominal pain. Has two abdominal ultrasounds that are negative (one at a physicians clinic and the other at a novice center) and many hematological markers. She is then diagnosed as having an immune related gastrointestinal disease and is treated for ten months with no response. A new physician requests a CT scan which reveals advanced abdominal malignancy.

60. Cognitive Dissonance

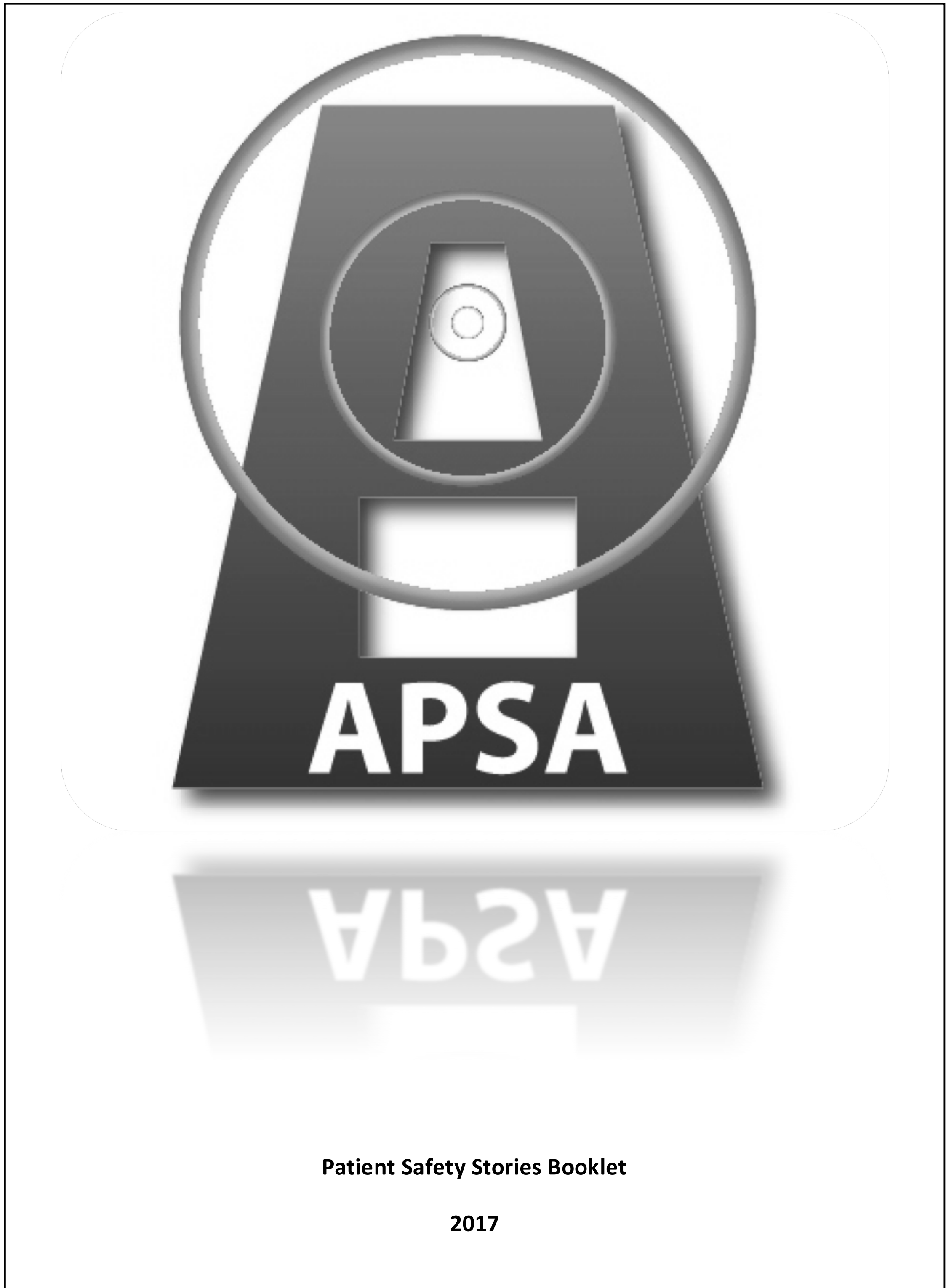
A healthcare provider on her way to hospital slipped and hit her head. The resultant wound was stitched. Despite this event she started to work. It was noticed later in the day that she was not totally alert, therefore, was advised to have a CT on her brain. However, she went home and slept and did not wake up.

____

Alexandria Patient Safety Alliance

For Safer Practice

Resource Booklet



Patient Safety Stories Booklet

2017