Manitoba
Health, Seniors and Active Living

Manitoba Health, Seniors and Active Living (MHSAL) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Mode of transportation (stretcher service) utilized for an unstable patient transfer

Summary:

A patient recovering from a surgical repair of a fractured hip was deemed stable post-operatively on day six of his/her hospitalization. The plan was for the patient to be re-patriated back to another acute care facility for ongoing recovery and rehabilitation. The acute care facility was located outside of the Service Delivery Organization's (SDOs) jurisdiction.

On the date of transport arrangements, it was communicated to the receiving facility that the patient was stable. It was decided amongst the two facilities that arrangements for transport back to the originating facility where the patient had first presented would proceed with making the transport arrangements. The receiving facility contacted the Medical Transportation Coordination Centre (MTCC) who dispatched transportation for the patient to be picked up.

The patient was not picked up by Emergency Response Services (ERS) on the date of expected transfer due to backlog in priority calls.

It was unknown at the time of the event by the sending facility staff that a pilot project was underway in the other SDO's jurisdiction. The pilot project consisted of utilizing a Patient Transport Service (Stretcher Service) for all stable patient transfers to assist in alleviating the backlog of ERS.

The following day the patient was picked up later in the afternoon via a stretcher service. The staff uniforms appear very similar to ERS and staff at the acute site thought it was ERS.

The length of time of transport from one facility to another due to location was approximately 1.5 hours. Upon arrival the patient was deemed to be unstable and in hypovolemic shock. The patient was immediately transferred to a higher level of care.

Keywords: Stretcher Services

This review is based on a single event.

Findings of the Review:

The event was multifactorial that included communication breakdown during handovers at transition points/ patient change in medical status/ ongoing monitoring prior to & on actual date of delayed transport.

Arrangements for transport/repatriation of the patient occurred by the receiving facility. The receiving facility called MTCC and provided information of a stable patient transport. MTCC proceeded to book a Patient Transport Service (stretcher service) as the information provided met the criteria for this mode of transportation. It was unknown at the time by both parties i.e.) receiving and sending facilities that a pilot project was occurring with MTCC dispatch. The pilot project was to utilize a Patient Transport Service when ERS was backlogged &/or when there was limited human resources. Only stable patient transfers requiring no medical interventions/ monitoring during transport fit the criteria to use the chosen mode of transportation. The receiving facility had been notified by MTCC regarding any delays which was communicated by phone to the facility whom requested the transport. Therefore, the sending facility was unaware about the extended delay. According to policy the process for Interfacility Transport indicates that the sending facility is to arrange transport by calling MTCC.

Subsequent communication breakdown of patient needs/monitoring and updated change in patient status just prior to & on the actual date and time of transport occurring was not communicated back to MTCC & or the receiving facility.

Uniforms of the Patient Transport Service attendants (stretcher service) are very similar in appearance to ERS coupled with limited communication of the pilot project increased the likelihood that staff at the sending facility assumed the attendants were ERS at the time of patient transport.

There had been a change in patient status over the course of the delay (24h) post transport arrangements. Daily bloodwork monitoring had not been ordered/continued as the patient had technically been deemed medically stable and discharged one day prior and was awaiting transport. On the date of actual transfer the patient was re-assessed, however the previous days bloodwork was communicated to the responsible clinician

which further led to an inaccurate full picture of the patient and unknown further drop in his/her hemoglobin from 74 to 54 (120-160 range is normal). The threshold for the patient to receive a blood transfusion was indicated to be a hemoglobin level less than 70 for further corrective action/treatment. There also had been limited Intake and Output (I&O) monitoring of calculations during the patient's hospital stay. The patient was noted to be in a daily fluid balance overload ranging anywhere from 1-2 Liters per day masking the unknown continuous blood loss of an undiagnosed stomach bleed.

The transport took 1.5h due to location of receiving facility. Upon arrival the patient was unstable and in hypovolemic shock (hemoglobin 54) and in congestive heart failure. The patient immediately was transferred to a higher level of care by ERS with an unknown stomach bleed non-related to his/her surgical procedure.

System Learning:

Recommend the Critical Care Medicine Team (CCMT) review the following two policies: *"Interfacility Transfer"* (CLI.5310.PR.004) & *"Information Transfer at care transition-Acute Care"* (CLI. 4510.PL.005) to incorporate a process for delays greater than 12h. This may include and not be limited to contacting MTCC for a status update on transport services estimated time of arrival; reporting changes in patient status to ensure the chosen method/mode of transportation remains appropriate and safe.

Re-educate 80% of clinical staff on the revised *two* policies & procedures including and not limited to MTCC's role in booking the appropriate mode of transportation i.e.) STARS, ERS, and Patient Transport Services

Recommend Shared Health in conjunction with all SDO's create a communication campaign to raise awareness of the pilot project (Utilization of Transport Services) so that all staff are informed on the level of training of attendants & criteria of patients for a Patient Transport Service to ensure that this mode of transportation remains appropriate at the time of transfer.

Recommend different colored uniforms for Patient Transport Services as both (ERS and Patient Transport Services) appear very similar.

Re-educate 80% of clinical staff at the site on calculating accurate Intake & Outputs over 24 hours including communicating /reporting of fluid imbalances (positive/negative).

Recommend a Medical Standards Review be completed at the site for learning opportunities.

Date of Posting: