Manitoba Health

Manitoba Health 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

Ruptured Ectopic Pregnancy

Summary: A patient who was ~5 weeks pregnant presented to the emergency department (E.D.) with complaints of spotting and abdominal pain. The patient was triaged as a CTAS-3. After waiting for 8 hours the patient left without being seen.

The following day the patient went to a family doctor who had ordered Win-Rho to be administered due to incompatible RH factors. This was administered as an outpatient at the E.D. The patient received the Win-Rho and was discharged home without being seen by a physician.

One week later the patient presented to another E.D. with increased abdominal pain and an ultrasound was performed indicating a ruptured ectopic pregnancy. The patient then required emergency surgery for the removal of the fallopian tube.

Keywords: Ruptured ectopic pregnancy

This review is based on a single event.

Findings of the Review:

The E.D.'s flow was impacted by a "bed lock" (patient's in the E.D. waiting to be admitted left limited room to assess/treat other patients). Typically 7-8 E.D. beds out of 15 are occupied with admitted patients waiting for a bed on a unit. After an 8 hour wait to see a physician, the patient left the emergency department without being seen. Bloodwork was drawn during this time indicating a positive pregnancy, however no ultrasound was ordered or performed.

The patient was triaged as a CTAS level 3 with abdominal pain/obstetrical concern with vaginal bleeding and abdominal pain. However, the the ERP was not notified of same.

Multiple surrounding E.D.s have recently closed/have reduced hours which has led to an increase in patient presentations at the site the event occurred.

The patient's abdominal pain continued to worsen and she returned to a different E.D. 7 days later and was diagnosed with a ruptured ectopic pregnancy, requiring surgery.

System Learning:

Educate all emergency room staff on signs and symptoms of obstetrical complications/ectopic pregnancy.

Explore the development of a nurse initiated order set for quiry ectopic pregnancies.

Suggestions:

Explore the possibility of increasing the visibility between the triage area and the waiting room by a) replacing the partition wall with appropriate translucent barrier (ie. glass) and/or b) replace the surveillance monitor with a larger screen with the facility campus review being conducted.

Consider exploring a nurse practitioner (NP) model and/or a fast track with additional ER physician hours at the regional sites.