2425-035

Patient Safety Learning Advisory

Patient Safety Event: A patient had an ST elevation myocardial infarction on an electrocardiogram (EKG) that was missed.

Why was this a Critical Incident?

A 14-hour delay in the treatment of an ST elevation myocardial infarction (STEMI) is considered to cause significant harm to the patient's cardiac function.

What happened in the incident?

A patient presented to the emergency department (ED) with chest pain. Nurse initiated chest pain orders were started, including obtaining an EKG and drawing bloodwork. An EKG was performed at 2003hr indicating ST elevation, but was interpreted as a non-ST elevation myocardial infarction (NSTEMI). At 1000hr the following day the missed STEMI was discovered, and the patient was transferred to the cardiac catheter laboratory for immediate treatment.

What is the Health Care System learning?

The appropriate process was not followed for the STEMI. The STEMI was unrecognized and not treated for 14 hours.

What are the recommendations?

Take to ED council for discussion process of reviewing EKG's performed in the region with the suggestion that ED nurses sign/initial the EKG when handed from the diagnostic services technician.

Plan a virtual education session to review STEMI/NSTEMI (related to missed STEMI).

*SUGGESTIONS TO ENHANCE PATIENT SAFETY

The information and suggestion that follows was brought forward during the Critical Incident review. These factors did not contribute to the critical incident; however, the suggestions are being shared as opportunities for system improvement. This information will not be included in the Manitoba Health Patient Safety Learning Advisory but will be shared with the respective Senior Leaders. These suggestions are not intended for follow up reporting to Manitoba Health.

Implement an ED nursing mentorship program.

Keywords: STEMI

Glossary:

Your privacy is important to us, so in this summary we have removed any details which would help identify the subject of this event. It's important that we can learn from safety events and make changes to improve the care we provide.