

University of Michigan Hospitals & Health Centers

Sentinel Event Executive Summary

Event:

Description: A 9-year-old female underwent surgery on (date). In Mott PACU, she was given one dose of Fentanyl (50mcg, given based on an order of 15 mcg which was misread as 15mg.) She experienced a transient drop in oxygen saturation. Dilaudid (hydromorphone) was ordered for the patient's pain control by way of Patient Controlled Analgesia (PCA) intravenous delivery. The patient was transferred to general care along with a PCA pump, pump tubing and a PCA syringe of Dilaudid taken from the stock supply in the PACU. On the unit, the PCA was set up and hooked to the patient. The bedside nurse unintentionally delivered a single dose to the patient. The patient exhibited respiratory depression leading to cardiac arrest. A code was called but the patient was unable to be resuscitated. After the arrest, it was noted that the concentration of Dilaudid in the PCA syringe was 1mg/ml rather than 0.1mg/ml, as ordered.

Event Date:

Institutional Discovery Date:

Self reported to JCAHO:

Root Cause Analysis Due Date:

Sentinel Event Review Team	
Fixed Team Members	Variable Team Members
Chief of Staff, Office of Clinical Affairs	Biomedical Engineering
Director, Nursing Services	RN, Mott Staff Nurse
Hospital Administration Representative	RN, Mott PACU Staff Nurse
Risk Management Representative	RN, Mott PACU, Manager
Quality Improvement Representative	RPh, Pharmacy, Manager
	MD, Adult Anesthesia, Director Acute Pain Service
	RN, UH Staff Nurse
	MD, Peds Anesthesia
	RN, UH PACU Staff Nurse
	RN, Mott Acute Pain Service
	PharmD, Pharmacy
	MD, Peds Emergency
	MD, Peds Anesthesia
	RN, Adult PACU, Manager
	RN, Graduate Student
	RN, Clinical Nurse Specialist
	RN, UH Manager

University of Michigan Hospitals & Health Centers Sentinel Event Executive Summary (continued)

Meeting History:

Fourteen areas of JCAHO Minimum Scope of Analysis were reviewed; twelve required for the category of medication error, two additional areas were added. After the initial analysis, 6 subcommittees were formed to address specific areas.

1. PCA Policies and Procedures
2. Medication Control
3. Equipment Issues
4. Monitoring of Patients with PCA Therapy
5. Communication Issues
6. Resources

An initial debriefing meeting was held on (date). Four root cause analysis meetings were held on (dates). Subcommittee meetings were held in addition to the root cause analysis meetings. All members of the review team participated in one or more of the subcommittees. Other staff members with content expertise were solicited to participate in the subcommittees as needed.

Additional Subcommittee Participants:

Respiratory Care, Manager
RN, Materiel Services
MD, Veterans Health Administration
MD, Pediatric Surgery
RN, Nursing Services, Manager
RN, Adult Acute Pain Service
RN, Adult Acute Pain Service
MD, Peds Surgery
MD, Anesthesia
RN, Mott Staffing Nurse

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