



PATIENT SAFETY RESOURCES

EHR ERROR EXACERBATES ADVERSE EVENT DURING IHT

By Jeffrey Timperi, CRICO

DESCRIPTION

Failure to monitor a patient's physiological status and lack of standard operating procedures during intra-hospital transport resulted in the death of a 60-year old female.

KEY LESSONS

- Standardizing transport and documentation processes amongst providers limits confusion.
- Hospital transporters need to follow a standard operating procedure for checking patient oxygen tank levels.
- An entry error by a clinician to a patient's electronic health record exacerbated the patient's adverse event during an intra-hospital transport.

CLINICAL SEQUENCE

A 60-year-old female with a history of vascular risk factors, presented to her local Emergency Department (ED) with a complaint of bilateral, lower extremity pain and draining ulcers. She was diagnosed with cellulitis. The patient had arrived with a home oxygen tank and connected tubing, but since her blood oxygen level was low, she was given supplemental oxygen in the ED. The nurse erroneously selected "room air" on the patient's EHR (instead of documenting the supplemental oxygen volume and mode (cannula or face mask)).

As the patient was to be admitted, an intra-hospital transport (IHT) request was submitted and a hospital transporter arrived to take the patient to a floor. The IHT form had no note regarding the patient's need for oxygen; she was transported with her home equipment. During the transfer of the patient into a room bed, the patient suffered a pulseless electrical activity (PEA) arrest.

Meanwhile, a nurse attempting to connect the patient's home tube to the wall in her room discovered that it was too short, creating a delay. At that point, the nurse realized that the patient's home oxygen tank was empty.

The patient was stabilized, then transferred to the ICU. Her blood pressure was 76/37; she was intubated and placed on a ventilator. In the ICU, the patient suffered two additional PEA arrests. Vasopressors and tissue plasminogen activator therapy was

started. The patient had a full neurological recovery, however, she could not be weaned from the ventilator and, per her advance directive, declined a tracheotomy.

The patient was terminally extubated and died.

ALLEGATION

The allegation cited a failure to monitor the patient's physiological status.

DISPOSITION

The case was settled in the mid-range (\$500,000-\$999,999).

ANALYSIS

Expert review of this case found that transporters at the hospital do not follow standard operating procedures

During review of this case, it was noted that transporters at the hospital do not follow a standard operating procedure for checking oxygen tank levels and there has been no formal training provided on how long an oxygen tank will last given the liters of oxygen in use. Further, it was commented that information on how to check oxygen tank levels is not posted in patient rooms. The intra-hospital transport (IHT) process and form documentation should be standardized amongst providers and within the institution.

Refer to this document for [Patient Safety Guidance on Intra-Hospital Transfers](#)

Documentation is critical

In addition, a clinician (the ED nurse) did not correctly document key patient information to the patient's EHR. This error exacerbated the patient's adverse event during the IHT. Supervisory review of the patient's EHR prior to the IHT may have mitigated the patient's adverse event. Refer to this document for some ideas on how to record this sort of note: CRICO Documentation Best Practices

Formal training should be provided

Formal training should be provided for hospital transport staff on how long an oxygen tank will last. Further, this information should be clearly posted in all patient rooms.

